

Bradford Teaching Hospitals NHS Foundation Trust

Bradford Royal Infirmary

Inspection report

Trust Headquarters
Bradford Royal Infirmary
Bradford
BD9 6RJ
Tel: 01274364305
www.bradfordhospitals.nhs.uk

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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 Bradford Royal Infirmary

Inspected but not rated



The service cared for patients and kept them safe. 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 initial risks to patients. The service managed safety incidents well and learned lessons from them.

Staff provided good care and treatment. 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 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:

During the inspection, there were some gaps in patient records which included intentional rounding charts, comfort rounds and pain management logs.

There were areas of improvement needed for the oversight of sepsis management which were highlighted in the most recent performance audit and when checking patient records we found a delay to treatment being administered to one patient within the recommended one hour timeframe.

At the time of inspection there was no designated mental health room for patients presenting to UEC in mental health crisis. Patients were supported in standard bays which could be stripped-out to reduce potential ligature points.

During the inspection staff told us that patients presenting to the department in mental health crisis often experienced long waits due to difficulties accessing appropriate onward care pathways.

Staffing did not always match the planned numbers due to increasing absence rates.

Urgent and emergency services

Inspected but not rated



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 West Yorkshire below:

A summary of CQC findings on urgent and emergency care services in West Yorkshire.

Provision of urgent and emergency care in West Yorkshire was supported by multiple provider services, stakeholders, commissioners and local authorities.

We spoke with staff in services across primary care, integrated urgent care, community, acute, mental health, ambulance services and adult social care. Staff continued to work under sustained pressure across health and social care and system leaders were working together to support their workforce and to identify opportunities to improve. System partners worked together to find new ways of working, linking with community services to meet the needs of their communities; however, people continued to experience delays in accessing care and treatment.

During our inspections, some staff and patients reported difficulties with providing and accessing telephone appointments in GP practices. Some of these issues were caused by telephony systems which were being resolved locally. We found inconsistencies with triage processes in primary care which could result in people being inappropriately signposted to urgent and emergency care services. However, a number of staff working in social care services reported good engagement with local GPs.

We visited some community services in West Yorkshire and found these were generally well run. Service leaders were working collaboratively to identify opportunities to improve patient pathways across urgent and emergency care. These improvements focused on meeting the needs of local communities and alleviating pressure on other services. There were strong partnerships with social care and community teams, so patients had the right support in place on discharge.

However, we inspected one intermediate care service and found it could only take referrals from an acute trust, which meant there were no step-up facilities for patients in the community. The service struggled for ward space to deliver therapeutic activities and there were no communal spaces for patients to meet together or engage in group therapy. Plans were in place to provide additional facilities and to reconfigure the existing layout to provide communal spaces.

The NHS111 service was experiencing significant staffing challenges and were in the process of recruiting a high number of new staff. Staff working in this service had experienced an increase in demand, particularly from people trying to access dental treatment although a system was in place to manage the need for dental advice and assessment. Due to demand and capacity issues, performance was poor in some key areas, such as providing a call back to patients from a clinician.

The ambulance service had an improvement programme in place focused on performance and staffing. Whilst we saw some improvement in ambulance response times and handover delays, performance remained below target. We identified impact on other services due to the availability of 999 responses; for example, a maternity service had to close temporarily to keep women safe, due to system escalation and because ambulance responses couldn't be guaranteed in an emergency. Staff working in social care services also experienced lengthy delays in ambulance response times which further impacted on their ability to provide care to their residents.

Urgent and emergency services

We inspected some mental health services in Wakefield which were delivering person-centred care and responded to urgent needs in a timely way. Staff worked in multi-disciplinary teams and collaborated with system partners.

People's experiences of Emergency Departments were varied depending on which service they accessed. Some Emergency Departments had long delays whilst others performed relatively well. In services struggling to meet demand, patient flow was a key factor. Poor patient flow was primarily caused by delays in discharge with a high number of people fit for discharge unable to access community or social care services.

Staff working in some social care services reported significant challenges in relation to unsafe discharge processes, this included a lack of information to support their transfer of care and we were told of examples when this resulted in people having to return to hospital. Local stakeholders had a good understanding of this problem and were looking to improve pathways and discharge planning.

Staffing and capacity issues in both care homes and domiciliary social care services have at times impacted on timely and safe discharge from hospital.

We found services were under continued pressure and people experienced difficulties accessing urgent and emergency care services in West Yorkshire. System and service leaders across West Yorkshire were working together to seek opportunities for improvement by providing services and pathways to meet people's needs in the community; however, progress was needed to demonstrate significant improvement in people's experience of accessing urgent and emergency care.

Summary of Urgent and Emergency Care at Bradford Royal Infirmary

We carried out this unannounced focused inspection of the Urgent and Emergency Care department (UEC) at Bradford Royal Infirmary in April 2022 as part of the Integrated Care System (ICS) review for West Yorkshire. The purpose of which was to support improvement in patient experience and the quality of care received when accessing services and pathways across urgent and emergency care and the wider ICS.

The UEC is open 24 hours a day, seven days a week and sees patients with serious and life-threatening emergencies. There is a separate paediatric emergency department dealing with all attendances under the age of 16 years. Patients present to the department either by checking themselves in via a dedicated reception area or arrive by ambulance via a dedicated ambulance-only entrance.

Bradford Teaching Hospitals NHS Foundation trust is responsible for providing hospital services for the people of Bradford and communities across Yorkshire. They serve a core population of around 500,000 people and provide specialist services for some one million people.

Our inspection had a short announcement (around 30 minutes) to enable staff to meet with us and for us to carry out work safely and effectively.

At our last inspection we rated the trust overall as Good.

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

See the urgent and emergency care section for what we found.

Urgent and emergency services

How we carried out the inspection

At Bradford Royal Infirmary, we spoke with nine patients and 23 staff, who included nursing, medical, administration staff, cleaners and service leads. We observed care provided, reviewed relevant policies, documents and patient records.

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

Is the service safe?

Inspected but not rated



Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, but, not everyone kept up-to-date with it.

Nursing staff received and kept up-to-date with their mandatory training. At the time of the inspection, overall training compliance was 91.5% against the trust target of 85%.

Not all medical staff kept up-to-date with their mandatory training. We saw low compliance rates in resuscitation training (59.26%), information governance (63.51%) and fire safety (70.27%).

We saw evidence that the mandatory training was comprehensive and met the needs of patients and staff, including recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Managers monitored and alerted staff when they needed to update their training.

We saw some examples in staffing rotas where mandatory training had been cancelled to allow cover for staff shortages on the department.

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.

Nursing staff received training specific for their role on how to recognise and report abuse and were all trained to the relevant level. The compliance rate for safeguarding adults training was 93.27% and safeguarding children training 100%.

Medical staff received training specific for their role on how to recognise and report abuse, with overall compliance rates of 89.19% for safeguarding adults and 93.24% for safeguarding children. However, not all medical staff had attained the recommended level two and level three safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The patient records system allowed staff to check through historical patient information and helped inform decision making around safeguarding concerns.

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Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff within both the adult department and paediatrics were able to explain the safeguarding reporting procedures and provided examples of safeguarding referrals they had made. There was an adult safeguarding team within the department who were readily accessible throughout the day to provide support and advice, as well as 'safeguarding champions'. Information and guidance on safeguarding awareness was clearly displayed and easily accessible for staff.

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 and implemented action plans to maintain standards.

All areas were clean and had suitable furnishings which were clean and well-maintained. We saw the correct storage of cleaning materials and mop heads in-line with control of substances hazardous to health (COSHH) guidelines.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service generally performed well for cleanliness. Patient-Led Assessments of the Care Environment (PLACE) annual audits were stopped in 2020 as a result of the pandemic in-line with national guidance and the trust developed its own internal programme based on PLACE principles. The department consistently scored 95% and above in all cleaning audits since January 2022.

Staff cleaned equipment after patient contact, and we saw evidence of labelled equipment to show when they were last cleaned. In a random sample of audits, we saw scores ranging between 80%-100% in nine audits relating to decontamination of pulse oximeter and allocation of blood pressure cuff cleaning and 100% for the last five department commode cleaning audits.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were observed to be wearing appropriate PPE and were bare below the elbow. There were numerous sinks in the department with hand gel and handwashing instructions on posters displayed near the sinks. Staff were observed washing their hands before and after patient contact. The department consistently achieved 100% compliance in hand hygiene audits over the last three months and scored 90.24% on the most recent Matron and IPC audit.

Within the main entrance to the department there was a dedicated health care assistant available to complete COVID19 screening for patients upon their arrival. The most recent COVID19 screening audit highlighted that 100% of patients were swabbed upon arrival.

There were notices displayed reminding the public to wear face coverings and the layout of the waiting area promoted social distancing for patients, although, during busy periods overcrowding was possible.

We inspected five treatment bays, all appeared visibly clean. Disposable labelled curtains were used and all mattresses were clean and free from breaks.

All sharps bins were dated, signed and less than $\frac{3}{4}$ full.

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.

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The design of the environment followed national guidance. Access to the department was clearly signposted, along with trust guidance on the criteria for attending UEC. The department clearly displayed waiting times for patients upon their arrival.

COVID19 screening was completed inside of the main entrance of the department by a health care assistant (HCA) who also offered PPE to patients and ensured that any COVID positive patients were separated from non-COVID patients. The HCA was also available to monitor the waiting room and escalate any concerns to nursing staff regarding potentially deteriorating patients.

Patients with symptoms of COVID19 were swabbed in a doored cubicle by a separate member of the nursing team.

Security support was available for the department 24 hours a day to promote the safety of staff and patients.

Paediatric patients (children under 16 years) were directed through a secure door into a separate waiting area. Paediatric patients with symptoms of COVID19 were escorted straight to one of the six cubicles within the paediatrics department.

The departmental public reception area was spacious and at the time of our inspection had enough spare seating for patients. There were vending machines and toilet facilities available within the designated waiting area. Patients were able to share personal information with reception staff away from the main waiting area.

Patient triage was accessed via secure doors from the reception area, consisted of four bays and had constant oversight from medical staff.

There were an additional three bays designated for ambulance arrivals and rapid assessments. Ambulance arrivals could be tracked via a screen linked to the Yorkshire Ambulance Service control room. At the time of the inspection activity levels appeared to be low in comparison to the reported norm, with the average ambulance handover time recorded as 15 minutes.

Adults post-triage were then either sent to the green zone which is the minor illness/injury area (minors) or sent to the amber zone (majors). During the day there was also a local clinical commissioning group (CCG) funded GP service to support with patients located in the waiting room and green zone.

The minor illness and injury department consisted of eight bays and was staffed by emergency nurse practitioners (ENP) and emergency department doctors. At the time of the inspection we were told that when the UEC is busy, acutely unwell patients can often be sent through to the minor's area for treatment and may not always have appropriate oversight from staff.

The majors department consisted of 18 cubicles and also a seating area with six chairs for patients deemed able to sit and wait. At the time of the inspection the department was staffed by four qualified nursing staff, a team leader, consultant, middle-grade medic and junior doctors. Staff told us that they were often short-staffed, and three nurses had to cover the department at times.

The new high dependency unit had eight cubicles, all with doors and monitors. All of the cubicles were negative pressure to support patients transferred from the resuscitation area and to carry out aerosol generating procedures (AGP).

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The resuscitation area had four cubicles, three with curtains and one cubicle with a door which promoted patient privacy and helped infection control during AGP.

The department had direct access to diagnostic services. Requests for diagnostic input and subsequent results were all accessed via the central electronic recording system used by the hospital.

The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment. We saw the resuscitation trolley was kept in the resuscitation area of the department and included all relevant equipment. There was a designated safety checklist in place and evidence the equipment had been checked each day and was fit for purpose.

On inspection we checked multiple consumable items from the stock cupboard at random, all were in date.

The service had suitable facilities to meet the needs of patients' families. Within the department there were two dedicated relatives' rooms located within a quiet area and we observed staff regularly taking time to update family members waiting within these rooms.

We saw evidence clinical waste was managed in a way that kept people safe. Arrangements were in place for the segregation, storage and disposal of waste.

We saw evidence of back-up generators receiving regular essential service and testing and the department fire risk assessment was in place and due for renewal in December 2022.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. Staff could identify patients at risk of deterioration, but, did not always review and update patient records to reflect this. Risk was managed at all levels within the trust via quality and safety meetings at both clinical business unit (CBU) and care group level, as well as during weekly departmental risk huddles.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw examples within patient records of staff undertaking rapid assessments using the national early warning score (NEWS) tool in order to promptly identify the most appropriate care pathway for potentially deteriorating patients. Regular audits evidenced that staff consistently repeated observations for patients with a NEWS score of two or above, as per national guidelines.

Staff completed risk assessments for each patient on arrival using the Manchester Triage System, a clinical risk assessment tool used in emergency departments, to ensure completion of a holistic assessment at initial point of contact. Patients were also allocated colour-coded wrist bands to make risks easily identifiable for staff. However, staff did not always ensure documentation such as intentional rounding checks, pain score evaluations and patient nutrition and hydration records were up-to-date during treatment.

Staff knew about specific patient risk issues and could explain the steps taken to identify these. We saw evidence of a robust standard operating procedure and guidance for monitoring patients at risk of venous thromboembolism (VTE), deep vein thrombosis (DVT) and pulmonary embolism (PE). The most recent audit results highlighted that the

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department performed well with the completion of D-dimer screening (a test which detects clotting activity), arranging diagnostic imaging and commencing treatment. However, follow-up appointments were not always arranged correctly, information leaflets were not being handed out to patients and improvement was required to ensure Wells scores (a test reflecting patient risk of DVT) were checked and documented.

In the case of sepsis, staff told us that when patients presented with a NEWS of five, a sepsis screening tool would be generated on the patient's record. However, this could be bypassed, and patients could potentially not be screened or clinically assessed as to whether they require treatment for sepsis or another condition. We were told by staff that during busy periods it was not always possible to access antibiotics for suspected sepsis within the recommended one hour timeframe and saw an example where a patient received their first dose of antibiotics approximately two hours and 45 minutes after attending the department.

We reviewed the department sepsis screening performance data since March 2021 and found that out of 10,470 patients with suspected sepsis, only 7,789 were screened upon admission. The department figures for treatment within one hour for patients with severe sepsis since April 2021 showed that out of 1591 patients with severe sepsis, 1348 received antibiotics within the recommended timeframe of one hour.

We saw up to date policies and guidance for managing potential falls, as well as evidence in patient records of falls risk assessments being completed by staff, specifically for patients over the age of 65 years. A total of six falls resulting in harm had been recorded between December 2020 and December 2021 and a further two in February 2022 for the same patient, one of which was deemed non-preventable.

We checked patient records for skin assessments and saw evidence of these being carried out alongside regular departmental audits as part of the department's back to basics initiative.

There had been one hospital acquired pressure ulcer recorded between February 2022 and April 2022 which was under review by the tissue viability team. Any specific learning areas would be discussed with the team following the outcome of the investigation.

The department staffing rota showed there were enough nursing staff and at least two shared decision-making (SDM) doctors available on the department 24 hours a day with relevant advanced life support (ALS) training. We were told some ALS training courses had been cancelled due to staffing pressures and the impact of the pandemic. However, the department planned for all band six and seven ward sisters to have up-to-date training by April 2023.

The service had 24-hour access to mental health liaison and specialist mental health support. During the inspection we were told that the department could access psychiatric liaison 24 hours a day. The department was also supported by a specialist band seven mental health nurse during core working hours to offer support and advice. Staff also completed risk assessments for patients thought to be at risk of self-harm or suicide and attempted to place patients in bays close to the nurses station with one to one support, when available, to mitigate risk due to there not being a designated mental health room for patients.

Staff shared key information to keep patients safe during shift changes and when handing over their care to others. All patient transfers were managed by silver command, a central hub on-site. We attended one of the daily briefings which demonstrated effective oversight and management of patient information throughout the hospital.

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Staffing

Due to increasing sickness rates and increasing patient numbers, the service did not always have enough staff with the right qualifications, skills, training and experience to match the planned staffing numbers. However, staff worked hard 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 where possible, and gave bank, agency and locum staff a full induction.

The COVID19 pandemic has brought additional pressure to all hospitals in the country due to staff either becoming infected or being required to self-isolate after contact with a positive person. There was also increased demand as patient numbers surged presenting to emergency departments with higher acuity.

The service did not always have enough nursing and support staff. Patient acuity and a sustained increase in patients attending the department meant that having enough staff to meet the demand had been a challenge and staff told us that they felt they needed more staff to be able to safely deliver care due to feeling exhausted. Staff we spoke with stated that due to staff absence and increasing numbers of patients, there was increasing pressure upon the department resulting in long patient stays. However, staff worked hard to keep patients safe.

The number of nurses did not always match the planned numbers. During the inspection the nurse staffing allocation board highlighted that there were between two and six less nurses on-shift than planned due to staffing pressures.

We saw evidence that the managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift and took steps to ensure cover could be allocated when required. The trust completed three daily staffing huddles and could adjust staffing levels to mitigate shortages via contact with silver command. We saw nursing staff transferred to the department from other areas and the matron completing clinical work to ensure adequate staffing levels were maintained.

The service had increasing vacancy rates due to difficulty retaining staff which the trust was addressing through active recruitment both locally and overseas, as well as offering current staff flexible working options to reduce current turnover rates.

Sickness rates within the department had also increased and during the inspection we were told that approximately 15 staff per week were absent due COVID19 and work-related stress.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We saw evidence that the trust made sure all bank and agency staff had a full induction and understood the service.

The service had enough medical staff available and they were able to keep patients safe. The trust provided over 16 hours of consultant cover each day, seven days a week in-line with the 16 hours recommended by the Royal College of Emergency Medicine (RCEM). The service always planned 24-hour consultant cover with a consultant physically present on the department between 08:00am and midnight, seven days a week. Between midnight and 08:00am there was an on-call consultant available. Out of hours there were also a minimum of two senior decision-making doctors available to treat adult, paediatric and trauma patients.

At the time of inspection, we were told that there were middle grade (MG) staffing shortages particularly at weekends and overnight. To address this issue, the trust allocated locum shifts six weeks in advance to ensure appropriate cover was in place.

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The service had a good skill mix of medical staff on each shift. However, staffing did not always match the planned number. We saw gaps in medical staffing of up to 13 hours per shift. However, we saw evidence of mitigation put in place by the trust to address these shortfalls, which included extending the working hours of doctors already on-shift and seeking support from junior doctors. Managers could also access locums when they needed additional medical staff and we saw evidence that a full induction to the service was provided before they started work.

Records

Staff kept digital records of patients' care and treatment. Records were clear and stored securely and easily available to all staff providing care. However, there were gaps in some patient records.

Not all patient notes were comprehensive. Although initial patient checklists were completed upon arrival, we saw gaps in intentional rounding documentation and pain management logs. The most recent audit of patient records completed in February 2022, as part of the back to basics initiative, highlighted that only five out of 10 records had satisfactory documentation. This has been identified as an area of development which is being focussed upon.

Records were stored securely and could only be accessed using the staff member's own log-in details. When patients transferred to a new team, there were no delays in staff accessing their records due to use of the centralised recording system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines and adopted the seven rights of medicines administration guidance. Medicines management compliance rates for nursing staff was 86.5% against a trust target of 85%.

Although most medicines records were accurate, they were not always up-to-date and not always reviewed regularly. We saw some gaps in patient records where analgesia and antibiotics had not been provided to patients in a timely manner.

Staff stored and managed all medicines and prescribing documents safely and we saw evidence that the clinical pharmacy team conducted reviews of interventions relating to prescribing of medication on the department. The data for February 2022 highlighted that 11 reviews were completed over a three-week period and that up to 30 patients were seen during each visit. The clinical pharmacy team reviewed stock medication and offered support and advice to staff to improve practice, as well as ensuring that all critical medications for conditions such as epilepsy, diabetes and Parkinson's disease were correctly prescribed.

The service followed policy and best practice guidelines to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw examples of patients being supported with one to one support and therapeutic interventions from staff prior to the use of any sedation. When sedation was used, we saw evidence that mental capacity and use of the best interests principles had been considered to promote patient safety and wellbeing.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

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Staff we spoke with knew what incidents to report, how to report them in-line with trust policy and provided recent examples to demonstrate their knowledge.

The department nurse manager told us that the trust shared learning with their staff about all safety events that happened elsewhere in the trust.

Staff understood the duty of candour and gave us examples of when the principles had been applied. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service and met to discuss potential improvements to patient care. There was evidence that changes had been made as a result of feedback and the department clearly displayed incident information and themes, as well as weekly learning points resulting from previous risk factors and incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and Managers debriefed and supported staff after any serious incident. At the time of the inspection there were 19 ongoing formal incidents being investigated. We also saw five examples of recent incidents which had been broken down into bitesize examples for staff of what had occurred, and the lessons learned from each.

Is the service effective?

Inspected but not rated



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 and staff protected the rights of patients subject to the Mental Health Act 1983.

Every patient attending the department had their mental health needs taken into consideration throughout the triage process with a further REACT screening tool being completed if any signs of mental health crisis were identified. A patient would then be provided with one to one support from a health care assistant (HCA) if they were deemed to be at risk of potential harm. There was no designated mental health room within the department for patients. The trust told us that there were treatment bays within the department that could have various furnishings and equipment removed to minimise potential risk of harm which were near the nurses' station. However, during busy periods this could be problematic to arrange.

The department followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The department received support from a band seven mental health nurse based on-site, as well as psychiatric liaison which could be accessed 24 hours a day.

Nutrition and hydration

Staff were able to give patients food and drink to meet their needs and improve their health. However, staff did not always accurately complete fluid and nutrition charts.

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Staff tried to make sure patients had enough to eat and drink, including those with specialist nutrition needs such as diabetes. The overall department score for the last bi-monthly nutrition audit from 1 February 2022 to 20 April 2022 was 86.4%. A total of 79 patients were included in this audit, all of which were able to access fresh water. However, during the inspection, nutrition and hydration recordings were not always consistent, with gaps noted in some patient records.

Staff used the nationally recognised malnutrition universal screening tool (MUST) for all admitted patients at risk of malnutrition.

Staff knew how to access specialist support for patients such as dietetics and speech and language therapists.

At the time of the inspection, food for patients was prepared in one of the staff offices which contained a microwave and temperature probe. The trust had formally submitted plans for a room to be allocated within the department to ensure a separate space could be made available to allow staff to prepare food and drinks without interfering with other staff activities based within the current setting.

Pain relief

Staff assessed and monitored patients to see if they were in pain, but, did not always give pain relief in a timely way.

Staff assessed patients' pain using a recognised tool. Staff prescribed, administered and recorded pain relief accurately in most cases, however, some patient records showed gaps and delays in administering pain relief.

Most patients received pain relief soon after it was identified they needed it or they requested it. The trust monitored the departments performance with administering pain relief and made sure feedback was provided to staff to address areas for improvement. An example we saw was the trust's response to the national royal college of emergency medicine (RCEM) Pain in Children report from January 2022, which would be used to drive further improvement.

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 had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits and we saw examples of quality improvement projects for delirium screening, infection control and neck of femur fractures. All of which were measured against national standards. Outcomes for patients were positive, consistent and met expectations, such as national standards and managers and staff used the results to improve patients' outcomes.

We saw evidence that managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and the information from the audits was used to improve care and treatment. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored within monthly clinical outcomes groups which provided assurance through learning and improvement to the Quality and Patient Safety Academy that the trust delivered the highest quality of care based upon national standards, guidance and best available evidence.

For acute trusts, NHS England's operational pressures escalation levels (OPEL) had been nationally defined as being levels one to four, with four being the highest level of operational pressure. At the time of the inspection the hospital was

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running close to full capacity, causing delays in patient transfers and discharge. Managers could investigate outliers at departmental level and through twice-daily silver command meetings. At the time of the inspection, there were three delayed discharges from the department due to a lack of available beds within the hospital which silver command had full oversight of and were taking the relevant steps to resolve.

From 05 April 2021 to 17 April 2022, a total of 148674 patients had attended the department with 7.29% (10839) reattending within seven days, less than the England average of approximately 9%.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust provided a full induction tailored to their role before they started work which gave a good overview of the department.

Managers supported staff to develop through yearly appraisals and constructive clinical supervision of their work, identified any training needs their staff had and tried to give them the time and opportunity to develop their skills and knowledge. Every member of staff received an annual appraisal which are undertaken by departmental line managers. At the time of the inspection there was an 89% completion rate.

Due to clinical pressures as a result of staff absence and increased numbers of patients attending the department, we were advised that some training sessions had been cancelled to prioritise cover on the department.

We saw practice education and development displays in the staffing areas focussing on the basic nursing care needs as well as more specialised areas of learning unique to the local population. Staff told us that they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We saw that additional training and career development via the faculty of emergency nursing (FEN) would soon be made available for all nursing staff based on the department. At the time of the inspection the department were waiting for additional login details for all nursing staff.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. We were told that there were opportunities for junior doctors to undertake fellowships while working within the department to support continuous professional development. The clinical educators also supported the learning and development needs of staff, as well as focusing upon learning areas identified during departmental audits to ensure any learning areas were promptly addressed.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw evidence of meeting minutes and news bulletins on display within the staff room which could be easily accessed.

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. During the inspection, we saw examples of multi-disciplinary working with occupational therapy and the frail elderly care team to support patient discharge from the department.

Urgent and emergency services

Staff worked across health care disciplines and with other agencies when required to care for patients. Senior staff advised that there are regular meetings held with third party agencies such as social care, homeless projects and volunteer services to support patients who regularly attend the department. The aim of which is to identify new support networks within the community and reduce the risk of unnecessary hospital admissions.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The department could refer patients to psychiatric liaison services 24 hours a day. During the inspection, we saw the department liaise with mental health services to seek appropriate advice to aid treatment and care. However, staff informed us that there is often a lack of beds for patients requiring psychiatric admission, as well as a lack of community-based resources for patients experiencing mental health difficulties to access when ready to leave the department.

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.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support. We saw multiple leaflets within the waiting area and the department which could be easily accessed. Staff advised us that there are plans for digital information to be made available for patients via the use of QR codes which could be scanned by mobile devices.

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 and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

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. We saw examples within patient records where staff had assessed and documented patients' capacity prior to commencing treatment in their best interests.

Staff gained consent from patients for their care and treatment during triage in line with legislation and guidance. However, this was not recorded on electronic patient records following triage.

Urgent and emergency services

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. We saw two examples where staff had completed relevant MCA documentation and followed appropriate guidance. Information documented was accurate and legible.

Is the service caring?

Inspected but not rated



Compassionate care

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

In the department 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 observed staff introduce themselves and explain who they were and their role. They spoke quietly to patients to try and ensure they maintained a level of patient confidentiality.

Patients we spoke with told us staff treated them well and with kindness and that they were happy with the care and support provided despite their frustrations with the long waits to receive it.

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.

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

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. We saw an example of staff support a patient who became distressed in an open environment and helped them maintain their privacy and dignity.

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 and undertook training on breaking bad news.

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.

Due to ongoing COVID19 restrictions, only patients who required carer support were allowed into the department accompanied. Patients and relatives told us that staff took the time to make sure that they understood their care and treatment.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the department patient feedback and the actions taken by the trust to act upon concerns were clearly on display. Within the staff room we also saw the emergency department compliments newsletter which included positive patient experiences and highlighted good areas of practice.

The feedback from the emergency department NHS friends and family test was generally positive with 68.28% reporting a good or very experience and 17.65% reporting a poor or very poor experience while receiving treatment. The trust reported that upon further analysis, the negative scores related to wait times within the department. In response to this, the trust had looked at ways to improve communication with patients and ordered a new screen for the reception area to clearly display waiting times. Staff had also been advised to ensure regular updates were provided to patients experiencing long waits.

Is the service responsive?

Inspected but not rated



Service delivery to meet the needs of 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 a lack of community-based resources there were delays in treatment and discharge from the service.

Managers planned and organised services so they met the needs of the local population. An example we saw was information displayed to ensure staff awareness of diabetic ketoacidosis due to the high prevalence of diabetes within the local population. Some senior staff also had active roles in groups supporting local initiatives such as knife crime prevention and suicide avoidance.

During the inspection we saw patients whose first language was not English, receiving support from multi-lingual members of staff to ensure their needs were clearly communicated. Patient information leaflets within the department were also provided in multiple languages.

Facilities and premises were appropriate for the services being delivered. However, due to the increasing numbers attending the department, patients could experience long stays within UEC and delays in treatment. Due to difficulty accessing community-based resources the department also had increasing numbers of regular attenders seeking support which could potentially be provided outside of hospital. Patients we spoke with told us that they had attended hospital as they could not get an appointment with their GP surgery and despite the long wait, knew they would be seen in UEC. In response to this, the trust attended a forum as part of the wider integrated care system looking at ways of reducing unnecessary attendance whilst ensuring patients access the most relevant support available to them.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke positively about the support of psychiatric liaison and the band seven mental health nurse with links to the department. However, the trust highlighted that there was a lack of suitable resources available within the community for patients experiencing mental health difficulties. We were told that patients experiencing mental health crisis would frequently present to the department to seek support and often there would be delays discharging patients due to difficulty accessing appropriate community-based services.

Urgent and emergency services

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. Coordination of care with other services and providers was often difficult due to a lack of community-based resources.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw adaptations which had been made to meet the needs of patients living with dementia. There was a designated dementia-friendly treatment room, specifically designed to be low-stimulus for patients with cognitive impairment. Staff supported patients living with dementia by using colour coordinated wristbands which helped staff to easily identify patients.

The service had information leaflets available in languages spoken by the patients and local community which would soon be easily accessible on mobile devices via QR codes. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from the trust interpreting service which could offer support with face-to-face interpreting, translation, braille and British sign language interpreting.

Access and flow

The trust faced challenges with access and flow which meant that they could not ensure people were able to access the department and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Patients could not all access the department in a timely way and the trust faced known challenges with access and flow. Managers and staff worked to make sure patients did not stay longer than they needed to. However, due to increasing numbers of patients attending UEC and wider pressures within the ICS, we were told that patients could often remain on the department for up to 20 hours and in the case of some mental health patients, 30 hours. At the time of the inspection three patients had been waiting on the department for over 15 hours, with the longest wait recorded as 17 hours and 48 minutes.

The most recent data provided by the trust showed us that 7.8% of patients attending between 03 April 2022 and 10 April 2022 stayed on the department for more than 12 hours.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. Figures for the week ending 10 April 2022 showed the department performed below this standard with 72.27% of patients seen within four hours.

The national standard for median time from arrival at the department to treatment is 60 minutes. However, the trust told us that there had been delays in treatment due to the surge in patients attending the department. This had been particularly problematic in the weeks leading up to the inspection. We saw that daily attendance in UEC had gradually reduced from 419 attendances on 13 April 2022 down to 356 on 20 April 2022. The most up-to-date data showed patients waited two hours and 38 minutes from assessment to treatment between 03 April 2022 and 10 April 2022. This was based on an average of 381 daily attendances.

Between 13 April 2022 and 20 April 2022, a total of 3064 patients had attended the department, with 272 (8.88%) patients leaving before being seen, an improvement on 10% of patients leaving the department in January 2022.

Urgent and emergency services

We saw the most recent data for ambulance handover times with 78.43% of handovers in April 2022 being completed within 15 minutes. The trust target of 85% had not been met since June 2021.

Managers and staff started planning each patient's discharge as early as possible. However, due to a lack of community-based resources or limited bed availability, it was not always possible to discharge or transfer patients in a timely manner, particularly for those with complex mental health and social care needs.

Staff supported patients when they were referred or transferred between services and monitored patient transfers and followed national standards using the SAFER patient flow bundle, a nationally recognised tool used to reduce delays for patients in hospital settings.

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 and the service clearly displayed information about how to raise a concern in all patient areas. Staff understood the policy on complaints and knew the process on how to handle them.

From 01 April 2021 until 31 March 2022 the department had received 118 complaints, 19 of which had been upheld and 13 only partly upheld. The department had only one complaint which had been referred to the Parliamentary Health Service Ombudsman (PHSO) within this timeframe.

Managers investigated complaints, identified themes and shared feedback with staff and learning was used to improve the service. Staff we spoke with could give examples of how they used patient feedback to improve daily practice and we saw examples clearly displayed in the staff room for ease of access. Staff knew how to acknowledge complaints and we saw examples where patients received feedback from managers after the investigation into their complaint.

The department matron created a compliments and complaints newsletter on a monthly basis and circulates to all members of the UEC nursing and medical team. This was also displayed on the noticeboards in the staff areas. If a staff member had been mentioned within a compliment, the Deputy Associate Director of Nursing sent a letter to the staff member to recognise their good work.

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.

We saw evidence the nurse management leaders had the relevant skills, knowledge, experience and integrity to run the service.

Urgent and emergency services

Nurse managers we spoke with understood the challenges to quality and sustainability. This was evidenced by the departmental training compliance levels and high levels of audit compliance.

We saw evidence of regular departmental audits and RAG rated action plans with evidence of progress against most of the actions.

The trust also acknowledged the current challenges with staffing, an issue which was actively being investigated to promote stability and sustainability.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust told us that they were exploring ways to change the current working model and facilities available within the department to ensure that UEC is used appropriately by the local population.

The trust demonstrated that it was working with wider integrated care system to promote the 'Choose Well' agenda which could potentially reduce number of daily patients attending UEC by approximately 150. This would help to ease current pressures placed upon the department and would also ensure patients received the most appropriate level of care and treatment.

Culture

Staff felt respected, supported and valued. 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. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff had been resilient in their response to the ongoing COVID-19 pandemic. However, staff had found their situation challenging and described being tired.

The trust had invested in the wellbeing of their staff, especially in response to the sustained pressure staff continued to face due to the pandemic. There was a recognition that the wellbeing and morale of staff was impacted over the past year, however, we found staff displayed resilience and hope despite these challenges.

Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining the urgent and emergency care system despite the tremendous pressure it was under.

Despite the difficult circumstances, staff were positive about working within the service and praised the teamwork and educational ethos. Senior managers told us that funding had been secured from the education department to enable every registered nurse within the department to become a member of the Faculty of Emergency Nursing (FEN), which allows access to multiple resources including a vast range of emergency department related clinical and non-clinical skills training for all levels.

Managers hoped that this would not only help drive recruitment and staff retention, but, also boost morale and enhance the skills of nursing staff.

Urgent and emergency services

Staff felt there was good support from senior members of staff and there was ongoing input from the hospital psychology team to promote staff wellbeing.

Staff felt able to raise any concerns regarding the department and had access to a freedom to speak up guardian with all relevant information clearly displayed within the staff room.

The trust told us that they had adopted a zero tolerance towards abuse directed at staff from patients. Staff were encouraged to report all incidents of physical and verbal abuse and had the support of the senior leadership team.

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.

We saw evidence of the effective use of governance processes to maintain high standards of performance at both departmental level and trust-wide.

Staff we spoke with clearly understood their role within the wider team and took responsibility for their actions.

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.

We saw evidence the trust had processes in place to manage risk. Bi-monthly risk meetings were held for service leads to identify key issues and learning points which were then disseminated to staff.

We saw evidence of regular quality audits completed across multiple areas within the department to ensure risks were adequately monitored and service delivery improved upon. This was also applied to monitoring delays in treatment due to increased numbers attending the UEC. The electronic database displayed patients' time spent on the department which both departmental staff and silver command had access to. At the time of the inspection the hospital experienced challenges with patient flow due to a lack of available beds. However, because of the monitoring protocols in place on-site, the trust had full oversight of all patients requiring transfers of care.

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.

We saw evidence of effective data management both during the inspection and when receiving additional data from the trust post-inspection.

Information was stored securely at department-level and could only be accessed by staff using a unique log-in

Information relating to patient access and flow was overseen by silver command on a continuous basis to ensure appropriate actions were taken in as timely a manner as possible.

Urgent and emergency services

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.

The trust held regular meetings with other external organisations to help improve patient experience. Staff from UEC had been appointed leads for roles such as knife crime prevention and suicide awareness due to their prevalence within the local community.

We also saw examples of the department's engagement with the Multi-Agency Support Team (MAST), which continued to provide support to older adults with frailty and patients with low-level mental health needs and difficulties with substance misuse.

The trust shared with us that the emergency department had delivered the Medical Emergency Response Incident Team (MERIT) to the wider trust and third parties. MERIT training forms an integral part of the NHS response to major, mass casualty and critical incidents, providing advanced medical advice at a range of emergency incidents.

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.

We saw evidence of initiatives such as Patient Experience and Reflective Learning (PEARL) teaching sessions which were in place to improve quality performance and to help with the development of staff knowledge and skills to further improve patient experience when accessing the service.

Staff told us that the trust adopted a positive educational ethos and continuous professional development was encouraged both internally and through collaboration with third party organisations such as the faculty of emergency medicine.

We saw examples of positive feedback provided to the department from the safeguarding team, highlighting good, proactive practice to protect vulnerable patients and effective collaborative working with social care.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure that there is a dedicated, fully risk-assessed room available for patients presenting to the department experiencing mental health crisis.
- The trust should ensure that there is a sustained improvement in the oversight and treatment of sepsis.
- The trust should ensure there is a sustained improvement in the quality of patient records to ensure that they are fully documented and up-to-date with all observations.
- The trust should continue to work with system partners to improve patient flow throughout the emergency care pathway.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, one other CQC inspector, a nurse specialist advisor with expertise in urgent and emergency care, a consult specialist advisor with expertise in emergency medicine and a CQC inspection manager. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.