

# Cambridge University Hospitals NHS Foundation Trust

## Addenbrooke's and the Rosie Hospitals

### Inspection report

Addenbrookes Hospital  
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### Ratings

#### Overall rating for this service

Inspected but not rated 

Are services safe?

**Requires Improvement** 

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 Addenbrooke's and the Rosie Hospitals

**Inspected but not rated** ●

Cambridge University Hospitals NHS Foundation Trust is one of the largest trusts in the United Kingdom. The trust is a 1,100-bedded teaching hospital, which provides acute and specialist healthcare for the local people of Cambridge, together with specialist services, dealing with rare or complex conditions for a regional, national and international population.

Addenbrookes Hospital provides emergency, surgical and medical care for local people and is the Major Trauma Centre (MTC) for the East of England region. It is a regional centre providing specialist services such as organ transplantation, cancer, neurosciences, paediatrics and genetics.

The hospital campus opened in 1962 and became a foundation trust in July 2004. The trust serves an estimated population of around 578,264 and employs approximately 11,000 members of staff

We carried out an unannounced focused inspection of Addenbrookes Hospital urgent and emergency care and medical care services on 21 March 2022. We had an additional focus on the urgent and emergency care pathway across Cambridgeshire and Peterborough and carried out a number of inspections of services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme demand.

As this was a focused inspection of urgent and emergency care at Addenbrookes Hospital we only inspected parts of our key questions: safe, responsive and well led. The inspection framework focused on five key lines of enquiry relating to critical care, infection prevention and control, patient flow, workforce and leadership and culture.

At our last inspection in 2018, urgent and emergency services at Addenbrookes Hospital was rated overall as good. It was good for safe and effective, outstanding for caring and well led, and requires improvement for responsive. Medical Care services was rated as good overall.

For this inspection we considered information and data on urgent and emergency care performance. This inspection was partly undertaken due to the concerns raised over how the organisation was responding to patient need and risk in the wider trust in times of high demand and pressure on capacity. We were concerned with waiting times for patients and delays in ambulance handovers.

We looked at the experience of patients using urgent and emergency care and medical care services at Addenbrookes Hospital. This included the emergency department, medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We visited services and departments that patients may encounter or use during their stay. We also went to medical wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

Due to the nature of the service, we inspected and reported on EAU4, an emergency assessment unit within the medical care report. This ward was led by urgent and emergency care staff.

# Our findings

## **A summary of CQC findings on urgent and emergency care services in Cambridgeshire and Peterborough.**

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 Cambridgeshire and Peterborough below:

### **Cambridgeshire and Peterborough**

Provision of urgent and emergency care in Cambridgeshire and Peterborough was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, urgent care, acute, mental health, ambulance services and in care homes and domiciliary care agencies (social care). Staff had worked very hard under sustained pressure across health and social care services. Staff reported feeling tired and frustrated due to the sustained pressure and the impact this had on their wellbeing and on the delivery of training.

We identified a need for more capacity in primary care to meet people's needs in Cambridgeshire and Peterborough. We found some concerns in relation to access for patients trying to see or speak to a GP; however, other services proactively reviewed patients' attendance at emergency departments and took action to reduce avoidable attendances and improve access to appointments.

We visited a primary care unit run by an acute trust; whilst this was working well, we were told it was addressing an issue in access to primary care and was a short-term solution. We were told of a GP liaison service which enabled GPs and Consultants to work together to discuss individual patient needs. This service had successfully supported a significant number of people to stay at home or to access an alternative pathway and avoid going to an Emergency Department.

Access to NHS111 services for people in Cambridgeshire and Peterborough was generally in line with or better than elsewhere in England. Performance was closely monitored and there were plans in place to address staff shortages, particularly for health advisors, and there was a successful on-going recruitment campaign.

System partners in Cambridgeshire and Peterborough had been part of a collaborative project to launch a Virtual Waiting Room within the Cambridge and Peterborough region. The initiative aimed to help patients who call NHS 111 receive the care they need while alleviating the pressure on Emergency Departments (EDs).

Staff working in ambulance services reported a significant volume of calls which were inappropriate for a 999 response and could have been dealt with in primary care or urgent care services. Staff also reported a high number of elderly people seeking support through emergency services because they felt their care packages were insufficient and did not meet their needs.

Ambulance crews also highlighted their frustrations with the variation in pathways at different hospitals across Cambridgeshire and Peterborough and that ambulance crews were not prioritised for accessing alternative pathways. By streamlining pathways and handover arrangements, ambulance crews felt they could be more efficient.

# Our findings

For many complex reasons, including ambulance handover delays and staffing shortages, there were not enough crewed ambulances to respond to 999 calls within national targets. This posed a risk to people in the community waiting for a 999 response.

Staffing shortages in some Emergency Departments impacted on the delivery of safe and effective care. Staff were not all up to date with mandatory training and did not always assess risks appropriately.

We visited a mental health service and found it met the needs of people who presented in the Emergency Department or transferred between acute and mental health services. However, staff within Emergency Departments reported problems in accessing mental health services and were not able to make referrals 24 hours, seven days a week. This impacted on the ability to provide appropriate care and treatment and moving patients to the appropriate service.

Whilst we found some examples of collaborative working focused on developing system wide resilience, we found Emergency Departments remained under significant pressure. Patients experienced significant waiting times in these departments and staff reported the challenges of caring for patients within the department for such long periods of time. Some staff felt too much risk was accepted and held within emergency departments and didn't always feel supported by system leaders.

Same Day Emergency Care pathways aimed to relieve the pressure from Emergency departments. However, these services also experienced staff shortages, and some were only available during set times. Opportunities were lost to use admission avoidance pathways for the frail and elderly and increasing the risk of patient harm such as falls and skin pressure damage'

Delays in discharge for patients in hospital were significant and impacted on their health and wellbeing. Staffing issues were also impacting on the social care provision in Cambridgeshire and Peterborough; although there were beds available in care homes, there was not always enough staff to enable admissions. The staffing issues were also present in domiciliary care agencies which reduced the availability of care at home.

Staff working across health and social care reported poor discharge processes. Staff working in care homes and domiciliary care services reported that patients were often discharged late at night and with insufficient information to ensure a safe transfer of care.

Staff working in these services also reported significant delays in ambulance responses, however they gave very positive feedback in relation to welfare calls received by GPs or 111 and 999 call handlers.

We found a lack of knowledge across social care services in relation to managing deteriorating patients. By increasing staff awareness, services may be able to meet people's needs without needing to request emergency services.

We observed some local and system escalation meetings and found there was limited, if any action taken in response to issues and risks escalated.

## How we carried out the inspection

We spoke with 74 members of staff including nursing staff, consultants, junior doctors, support staff and senior managers. We observed the environment and spoke with 14 patients and reviewed 30 sets of patient records. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

# Our findings

You can find further information about how we carry out our inspections on our website: [www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection](http://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection).

# Medical care (including older people's care)

## Inspected but not rated ●

- 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.
- Staff did not always complete risk assessments for each patient however staff identified and quickly acted upon patients at risk of deterioration.
- People could not always access the service and receive the right care promptly when they needed it due to pressures on capacity.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- 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.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

## Is the service safe?

## Inspected but not rated ●

We inspected but did not rate safe.

### 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.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. All patients described wards as being clean.

The service performed well for cleanliness. There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas. Environmental and cleaning audits were completed and exceeded the trust target of 95% in the last two months, from February to March 2022.

# Medical care (including older people's care)

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw staff cleaning the wards throughout our inspection. Ward cleaning records for December 2021 to February 2022 were completed to show cleaning was regular. Wards were furnished with disposable curtains and these had details of date of first use and when they should be changed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore the correct PPE including face masks in accordance with national guidance. All clinical staff wore uniforms that enabled them to be bare below the elbow to allow effective cleaning of their hands. There was hand gel outside wards to make sure people could clean their hands before visiting wards.

Monthly IPC audits were completed within the service. The audits included but were not limited to, hand hygiene compliance and nursing cleaning scores. Data submitted following our inspection showed that from December 2021 to February 2022 ward C7 (gastroenterology) had scored 92% in December and 93% in February and in December N2, a medical isolation ward, scored 93% which was slightly below the trust target of 95%. All other scores for medical wards were above the trust target.

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms.

During our inspection staff cleaned equipment after each patient contact, however equipment was not labelled to show when it was last cleaned. This meant there was no clear process in place to indicate which equipment had been cleaned.

## Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Staff used the call bell system and ensured that patients had these within reach where appropriate.

The design of the environment followed national guidance. The environment was designed and managed to ensure the safety of patients using them. All wards were easily accessed and signposted from the main entrance. All wards we inspected were arranged to ensure separate male and female bays, with separate toilet and washing facilities allocated to each bay.

The hospital had built covid surge capacity which was now being used as medically fit for discharge wards. The unit was detached from the main hospital building and could accommodate 37 patients. The unit was intended to accommodate patients for short stay, usually within 24-72 hours, but some patients had been on the ward for up to seven days. The unit was not set out for this length of inpatient stay and there was no communal space that encouraged patients to spend time away from their beds. There was therefore a risk of deconditioning. Deconditioning can happen as a result of spending time immobile, leading to poor health outcomes, particularly for older patients.

Staff carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. We found all checks were completed electronically and had been reviewed to ensure compliance.

# Medical care (including older people's care)

The service had enough suitable equipment to help them to safely care for patients and staff we spoke with did not report any shortages of equipment. Electrical appliances and equipment we checked during our inspection had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show this had taken place. We checked 15 pieces of equipment and these were all in date for their safety checks.

Staff disposed of clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps such as needles, were disposed of correctly in line with national guidance. Arrangement for control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards.

## Assessing and responding to patient risk

### **Staff did not always complete risk assessments for each patient however staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Scoring system (NEWS2) was used in the service to identify patients at risk of deterioration. NEWS2 is a point system tool used to standardise the approach for detecting deterioration in a patient's clinical condition. The NEWS2 was calculated and recorded on an electronic-based system. The generated NEWS2 score provided a prompt to the staff entering the data, to review if the patient was unwell and/or deteriorating and required a medical review. The trust submitted data showing NEWS2 had been above the trust target of 90% between December 2021 and February 2022.

Senior leaders told us that whilst compliance with NEWS2 was regularly overseen by nurses in charge and the departmental matrons, the fact that this was not included routinely in retrospective audit data was a known gap and was subject to a change request for the electronic patient record system. There was an evaluation team that audited some patient records however we were told that the sample size was small, and these audits were not frequent.

A venous thromboembolism (VTE) is a life-threatening condition where a blood clot forms in a vein. During our inspection there were four patients out of 26 within the EAU that had not had their VTE completed while on the ward. Data submitted by the trust showed that compliance with VTE assessment and reassessment was variable and did not always meet the trust target of 95%. On ward EAU5, 85.3% of admitted patients had been assessed, on ward EAU4 92.3% had been assessed and on ward N2 86.6% of admissions had received an assessment between December 2021 and February 2022.

Data submitted by the trust showed that compliance with falls risk assessment was variable and out of 25 medical wards four were within the trust target of 90% for each month between December 2021 and February 2022. The emergency assessment units (EAU) did not meet the trust target between December 2021 and February 2022, EAU4 averaged 73.09% and EAU5 was 88.15%.

Data submitted by the trust showed that compliance with nutrition screening did not always meet the trust target. All patients admitted should be 'nutritionally screened' within 48hrs of admission and the results of this screening acted upon. Screening involves a nurse answering a few questions about whether a patient has lost weight recently and they are eating. On ward EAU4 the score for February 2022 was 67.9% and EAU5 was 74.1% against the trust target of 90%.

Staff knew about and dealt with most specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs.



# Medical care (including older people's care)

Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff could describe the signs of sepsis and what treatment must be initiated in line with national and local guidance. This included completing the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner.

Staff shared key information to keep patients safe when handing over their care to others. There were regular huddles to discuss patient care. These were multi-disciplinary and discussed all aspects of patient care.

Shift changes and handovers included all necessary key information to keep patients safe. Each ward had a safety huddle and all staff attended the huddle and were updated on all key information. Safety huddles were multi-disciplinary which enabled staff to discuss safety concerns regarding patient care in order that problems could be rectified in a timely way. Information was also shared on electronic patient boards in terms of which patient referrals had been made and accepted.

## 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 efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.**

Due to national shortages of nursing and support staff and staff absence, the service did not always have enough nursing and support staff to keep patients safe. Staffing pressures were exacerbated by the pressures of the COVID-19 pandemic. The number of nurses and support staff did not always match the planned numbers.

On the day of our inspection, the actual nurse staffing did not meet planned nurse staffing level for all wards, but one which was ward EAU4 staffing was as planned. The EAU5 ward, wards C3, C4, K2 and CCU were one registered nurse and one health care assistant (HCA) less than planned.

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. The trust used a safer staffing tool to monitor staffing levels and ensured that staff were delegated appropriately across the service. Daily meetings enabled the staff team to identify any areas where staffing shortfalls occurred, and managers delegated staff accordingly. Staff we spoke with told us that staffing levels was a challenge and staff would often be moved to wards where patients needed them.

The ward manager could adjust staffing levels daily according to the needs of patients. There was an established escalation and mitigation procedure in place for ward managers to raise staffing issues and concerns. The trust used a safe staffing tool, which considered nursing activity as well as patient dependency. This enabled senior nursing staff to identify areas with staffing pressures and allocate staffing across the organisation.

Data provided by the service following our inspection showed that from December 2021 to February 2022 the wards that we inspected had an average fill rate of 93.45% for registered nurses. The health care assistant fill rate was variable across the wards with overall establishment at 101.48%, however wards P2 and Q2 averaged 77.76% between December 2021 and February 2022. In addition ward K3 (cardiology) ranged from 78.6% in December 2021 to 163.3% in February 2022.

# Medical care (including older people's care)

Staffing levels impacted on patient experience. Patients that we spoke with all spoke highly of the staff at the hospital but also raised concern over staff workload and capacity.

The trust used bank nurses to ensure staff familiar with trust policies and procedures were employed where possible and most wards were using bank and agency staff.

Within medicine as of February 2022, there was a 14.4% turnover rate for registered nurses and a sickness rate of 4.5%. The sickness rate was within the trust target of 5%.

Managers made sure all bank and agency staff had a full induction and understood the service. Due to ongoing issues with recruitment, vacancy and turnover of staff, the trust had a high use of bank and agency nurses. Data submitted by the trust showed that as of February 2022 there was a 27.22% use of bank staff and 29.34% use of agency staff within medicine.

The ward manager could adjust staffing levels daily according to the needs of patients. We saw matrons speaking with ward managers to make sure that staffing was appropriately allocated where there was higher acuity patients.

## Medical staffing

**The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.**

The service had enough medical staff to keep patients safe. On the wards we visited the actual number of medical staff matched the planned number. Most wards had dedicated consultants who were responsible for patients' treatment. The number of specialty consultants varied according to the specialty and ward size. Each consultant team had a registrar and junior doctors. Junior doctors were easily contacted and responded in a timely manner. All patients were seen by medical staff on a daily basis.

At the time of the inspection the trust did not have the vacancy rate for medical staff. However data from board papers showed the number of medical staff had increased by 3.7% in January 2022 against the previous year.

The service had turnover rate of 7.2% for medical staff.

Sickness rates for medical staff were low. The sickness rate for medical staff was 1.7%

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staffing was reviewed at daily meetings led by senior leaders.

The service always had a consultant on call during evenings and weekends. Staff told us they could contact a consultant on call if they needed to.

# Medical care (including older people's care)

## Is the service effective?

Inspected but not rated ●

We inspected but did not rate effective.

### 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. Examples included but were not limited to, national audit of dementia, and national heart failure audit. Performance in national outcome audits was variable. However appropriate action was taken to monitor and review the quality of the service and effectively plan for the implementation of changes and improvements required.

Outcomes for patients were generally positive, consistent and met expectations, such as national standards. The trust received an A grade rating in the recently published Sentinel Stroke National Audit Programme. Information about the outcomes of patients care and treatment was routinely collected and monitored. Ward managers displayed quality and safety information including results of the safety thermometer, complaints and friends and family test results to inform patients and visitors of their performance within the wards.

Managers and staff used the results to improve patients' outcomes. Audit results were discussed within specialties as part of their local governance and action plans had been put in place to address any developments. The trust had produced a cardiology action plan in order to address an increasing trend of patients waiting over 52 weeks.

Managers used information from the audits to improve care and treatment. We saw governance papers that showed action plans to improve performance against national audits and that these were reported through the quality committee to provide assurance to the trust board. Most staff we spoke with were knowledgeable of national audits and how their work contributed towards a culture of improvement.

### 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. We observed a multidisciplinary team board round at 2pm. This was attended by a nurse in charge, consultants, junior doctors, operational managers, physiotherapist, ward clerk, and a social worker. All patients were discussed, and action agreed to benefit the patients for example we saw how the input of the physiotherapist supported the planned discharge of a patient.

# Medical care (including older people's care)

Care pathways were multidisciplinary, and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in patients' medical notes so information was accessible about the outcome of the valuation and the ongoing care of the patients from each professional's perspective. It was clear which clinician had overall responsibility of care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with were aware of the mental health liaison teams and provided examples of cases where they referred patients to the service.

Patients had their care pathway reviewed by relevant consultants. In all records we reviewed, we found patients had a prompt consultant review on admission and throughout their stay on ward rounds.

## Seven-day services

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

Consultants led daily ward rounds on most wards, including on weekends. Patients were reviewed by consultants depending on the care pathway.

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.

## Is the service caring?

Inspected but not rated ●

We inspected but did not rate caring.

## 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. During the inspection, on all wards we witnessed staff interacting positively with patients.

Patients said staff treated them well and with kindness. We saw staff interact with patients who were living with dementia in a calm and caring manner. All seven patients that spoke to us were positive about their interactions with staff. We spoke with one patient who described how staff were excellent.

Staff followed policy to keep patient care and treatment confidential. When patients were being examined, staff drew the curtains to maintain privacy and the dignity of the patient. Nurses and medical staff were aware of their surroundings and moved away from busy areas to discuss patient care.

# Medical care (including older people's care)

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff provided examples of accommodating dietary requirements due to religious guidelines. Nurses and healthcare assistants supported patients to access the chaplaincy service when they wanted spiritual assistance. Patients were able to book appointments to see family and loved ones on the hand held video devices, this enabled visitors to see patients who may otherwise not be able to travel.

## **Emotional support**

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

Overall we found that staff provided patients emotional support and advice when they needed it however, we were told that at times, lack of resource and capacity issues meant that time was limited. Staff were worried that they were not able to provide all the assistance that patients might need.

The trust policy was that one person could visit their loved one in the hospital by previous arrangement. Whilst there was not many visitors on the wards we did observe staff trying to co-ordinate a visit with a patient on the phone.

Chaplaincy support was available. Patients' spiritual needs were considered irrespective of any religious belief or affiliation. The chaplaincy service supported spiritual care across the services and ensured the delivery of spiritual, pastoral and religious care was adequate and appropriate.

Staff undertook training on breaking bad news and on some wards there were rooms set aside that were used for this purpose.

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. We witnessed staff dealing with a patient who was agitated while having a clinical intervention. Staff took time to explain what was happening and provided reassurance throughout the episode of care.

## **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 confirmed they knew why they were in hospital, had time to ask questions, and knew what they were waiting for before they could go home.

Staff talked with patients and people involved in their care in a way they could understand, using communication aids where necessary. Staff had access to communication aids on the wards and these were used to help explain care to patients who may have difficulties expressing how they were feeling or were living with dementia.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patients we spoke with felt confident to raise concerns with staff and there was information displayed on the wards that outlined the process for providing patient feedback.

# Medical care (including older people's care)

Patients gave positive feedback about the service. Patients and families could give feedback on the service and their treatment and staff supported them to do this. Although the good score rate from survey results was generally high the response rate across the wards was variable. Between December 2021 and February 2022 ward P2 had a 100% good score and a response rate of 57% from all patients. Ward EAU4 had a 96.4% good score and 98 response rate from all patients.

## Is the service responsive?

Inspected but not rated ●

We inspected but did not rate responsive.

### 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.**

Managers planned and organised services so they met the changing needs of the local population.

The service worked collaboratively with external agencies to improve services provided by the trust. This included working with the local clinical commissioners, general practices and neighbouring NHS trusts to identify the needs for the local community and planning of clinical pathways to meet demands.

The service had plans to develop frailty unit to assess frailer patients earlier in the pathway. This was an initiative to reduce long term ward dependency for patients.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no mixed sex breaches at the time of our inspection. Staff knew the importance of reporting this so it could be monitored and could outline the process of reporting using an incident form.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a variety of specialist nurses who were available to offer advice and support to staff and patients. For example, the service had access to a tissue viability team to help patients developing or at risk from developing a pressure ulcer.

Facilities and premises were appropriate for the services being delivered. We visited the emergency assessment unit and ambulatory care wards. Patients referred to the emergency assessment unit had been assessed as needing short-term care which should be possible to provide in the same day. Due to capacity issues throughout the hospital some patients were staying longer in hospital than expected.

The N2 isolation ward admitted patients across specialities and was set up in response to the pandemic. The N2 included a COVID-19 assessment area for patients with the that were COVID-19 positive and required a medical assessment prior to treatment. The ward had 22 medical beds and had pathway to ED. Emergency ambulance staff were able to drop off patients directly onto the ward and helped free capacity when the emergency department experienced ambulance delays.

# Medical care (including older people's care)

Managers monitored and took action to minimise missed appointments. Whilst there were backlogs for treatment, managers took steps to ensure elective procedures were maintained at a time when the hospital was at capacity.

## 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 their needs. Staff we spoke with were understanding of the needs of patients living with dementia. On wards P2 and Q2 the senior sister had focused on preventing deconditioning. Deconditioning is a decline in function and for older people with frailty, this may start within hours of lying on a trolley or bed. The senior sister had contacted local businesses to source clothes to enable patients to change out of gowns provided by the hospital. We were told that this pilot had been positive in getting patients ready and prepared for discharge into community settings.

Wards were designed to meet the needs of patients living with dementia. The service had a specific ward dedicated to the assessment of frail patients. There was also specific wards designed for the care of older people.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community. The service was able to provide British Sign Language interpreters if needed. Managers made sure staff, patients, loved ones and carers could get help from interpreters when needed. Staff were able to arrange access to interpreters to support patients and relatives who were unable to speak or understand English during their stay.

Patients were given a choice of food and drink to meet their cultural and religious preferences. If patients had any special diet requirements staff were able to contact the catering team to ensure these needs were met.

## Access and flow

**People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Some patients were needing longer stays while they awaited treatment.**

At the time of our inspection the hospital had 77 patients who were medically fit for discharge but awaiting external pathways of care such as social care. Due to complexities in assessing patients who needed onward care, and the lack of packages of care available to social services, there were delays in getting patients out of the hospital. Hospital leaders recognised the impact that delayed discharges were having on the flow within the service and were aware of the issues with flow through the wider local healthcare system. Staff moved patients throughout the day and also at night. Staff told us patients were moved to free up capacity and this included ward transfers outside of ward hours including at night.

Managers monitored patient moves between wards and tried to keep them to a minimum. This was listed as a risk on the risk register due to the negative impact this has on patient outcomes for older patients and was being monitored to keep moves to a minimum.



# Medical care (including older people's care)

Managers monitored waiting times to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the pressures of the COVID-19 pandemic and the ongoing strain on capacity, some patients were waiting longer than agreed targets for treatment. The trust had a decline in referral to treatment (RTT) on completed admitted pathways in Medicine, within 18 weeks from 90.7% in November 2021 to 82.5% in November 2022. However, RTT performance was still higher than the national average of 78.8%.

The trust had a remedial action plan to improve patient flow for cardiology outpatients and this included monitoring of waiting lists against a projected trajectory to improve patient flow.

Managers and staff started planning each patient's discharge as early as possible. Staff started discharge planning when the patient arrived at hospital. The hospital had specific teams of discharge co-ordinators to support with discharge planning and coordinating onward care within the community.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. For January 2022 the trust was reporting delayed discharges at 6.35%, which was an increase of 1.54% from the previous year. According to data provided by the trust this was equivalent to 1,747 beds days for January 2022.

The service moved patients to maintain flow within the hospital. Staff were aware of the need to keep ward moves to a minimum and where there was a medical need however due to pressures with access and flow within the hospital patients were moved when needed.

## Is the service well-led?

Inspected but not rated ●

We inspected but did not rate well led.

### 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.**

The departments at the trust were grouped together under five divisions. The medical and older people care service primarily spanned across Division C and included specialities across the other divisions. The senior leadership team for each division included a divisional director, an associate director of operations and a divisional head of nursing. They were supported by the local leadership team including the clinical director for acute services, specialty leads including for department of medicine for the elderly (DME) and acute medicine, the deputy head of nursing and operation managers across the service. Staff told us that leaders were visible on the wards and spoke highly of the local support offered by matrons.

We met with the senior leadership team who spoke candidly about the pressures faced within the hospital and praised the work of their staff throughout the pandemic. The team demonstrated an awareness of the services performance and the challenges they faced. Leaders had developed plans to adapt the service to increase patient flow.



# Medical care (including older people's care)

Senior leaders were involved in decision making to support a safe and responsive approach to medical staffing and to maintain patient flow. Due to system wide pressures, this was challenging as patients were not able to be discharged due to issues with availability of onward care within the community. Senior leaders had piloted a GP liaison line that was being rolled out further. The GP line was monitored by consultants and allowed for patients to attend the most suitable medical pathway.

## 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.**

The trust operated a framework approach to support leaders in managing risk, issues and performance, which fed up from speciality meetings, through committees and then onto the board.

The service had arrangements in place for identifying, recording and managing risks. The divisions had a risk register which included a description of each risk, an assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring. The risk register was monitored within the governance framework and regularly reviewed. The clinical department patient safety and governance meetings within cardiology were well attended by a medical and nursing staff. The meetings reviewed performance such as discharges, quality performance key performance indicators and document compliance, risk register and patient safety alerts.

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible.

## Areas for improvement

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

### Action the trust **SHOULD** take to improve:

- The Service should ensure that patients are risk assessed throughout their stay within hospital (Regulation 12)
- The Service should ensure people can access services when they need it (Regulation 12).

# Urgent and emergency services

Requires Improvement ● ↓

- Although staff understood how to protect patients from abuse and the service worked well with other agencies to do so, compliance with safeguarding training did not always meet the trust target.
- The design and use of facilities and premises did not always keep people safe.
- The service did not always have enough staff to care for patients and keep them safe. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.
- Compliance with life support training for staff did not always meet the trust target.
- People could not always access the service when they needed it and receive the right care promptly due to pressures on capacity. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

However:

- 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.
- Staff assessed risks to patients, acted on them and kept good care records.
- The service planned 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.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and used systems to manage performance effectively.
- Staff felt respected, supported and valued by local leaders. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

## Is the service safe?

Requires Improvement ● ↓

Our rating of Safe went down. We rated it as requires improvement.

### 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. However, compliance with safeguarding training did not always meet the trust target.**

There were clear systems, processes and practices to safeguard patients from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding adults and children policies were in-date and accessible to all staff.

# Urgent and emergency services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with demonstrated a good understanding of their responsibilities in relation to safeguarding adults and children in vulnerable circumstances. The service used an electronic patient record system which had a safeguarding alert facility. When staff accessed a patient's record it would alert if there were any adult or children's safeguarding alerts. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff received training specific for their role on how to recognise and report abuse. However, not all staff were up to date with their training. For safeguarding adults training, 80% of medical staff had received level 1 training and 72% had received level 2 training. Level 2 training included the Mental Capacity Act, Deprivation of Liberty Safeguards and Prevent. For qualified nursing staff, 93% received level 1 training and 85% had received level 2 training. This did not always meet the trust target of 90%

For safeguarding children's training, 85% medical staff had received level 1 training, 77% had received level 2 and 56% had received level 3 training. For qualified nursing staff, 93% had received level 1 training, 89% received level 2 and 81% had received level 3 training. This did not always meet the trust target of 90%. The trust told us that during the pandemic, mandatory face to face training was paused and compliance rates were improving as the trust returned to recovery.

Staff followed safe procedures for children visiting. The paediatric emergency department was protected by buzzer and locked door systems to prevent non-authorized entry.

## 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.**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff followed infection control principles, including the correct use of personal protective equipment (PPE) such as disposable gloves and aprons. PPE was readily available in all clinical areas.

Staff adhered to 'bare below the elbows' principles to enable effective hand washing and reduce the risk of spreading infections. Hand sanitising units and handwashing facilities were available in all areas and handwashing prompts were visible for staff, patients and members of the public to follow. Staff were present at all entrances into the hospital to ensure patients attending the hospital sanitised their hands before entering.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning was carried out against schedules and cleaning records reviewed were up to date and demonstrated that all areas were cleaned regularly. Curtains were disposable and staff had recorded the date they were put up and all were visibly clean.

Although equipment was not labelled to show when it was last cleaned, we observed staff routinely cleaning equipment between patient use, including patient trolleys.

There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas.

# Urgent and emergency services

Monthly IPC audits were completed within the service. The audits included, but were not limited to, hand hygiene compliance and nursing cleaning scores. Data from December 2021 to February 2022 showed that all urgent and emergency services scored above 98% in the monthly nursing cleaning audits, and between 95-100% in the monthly hand hygiene audits.

In response to the pandemic, the trust had re-configured the emergency department (ED) and implemented 'red' and 'green' areas within the ED to maintain patient and staff safety. Red areas were designated as high risk COVID-19 areas. Green areas were designated as safe areas for patients not showing symptoms of COVID-19 and those with negative COVID-19 test results. Staff screened patients for signs and symptoms when they attended the emergency department, staff then followed the relevant pathways. There was rapid testing available for COVID-19.

There were processes in place for clinical waste management. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area. Waste was separated into different coloured bags to signify the different categories of waste. All sharp boxes we observed were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This was in accordance with HTM 07-01: safe management of healthcare waste. All sharp bins had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle-stick injuries.

## Environment and equipment

### **The design and use of facilities and premises did not always keep people safe.**

Clinical areas were not always suitable and appropriate for the service which was being managed in them. The urgent and emergency service comprised of the emergency department, major and minor trauma areas, a resuscitation area, a paediatric emergency area and an urgent treatment centre. The emergency department consisted of five minors' cubicles, seven resuscitation cubicles, and 14 majors cubicles. There was a dedicated paediatric emergency department. The urgent treatment centre was GP led but managed by the emergency department.

The department had a separate entrance for ambulances, which enabled critically ill patients to be triaged and transferred to the correct area. The ambulance cohort area had space for three trolleys. In order to meet the pressure caused by excess capacity and delays with ambulance handovers, the department established a temporary external fixture to relieve pressure on ambulances that were queuing. The area, which had been risk assessed, could accommodate six patients, and was staffed by ambulance personnel. This facility was used for looking after patients who would otherwise be held on an ambulance. However, staff told us the area could get very cold during the winter and there were no toilet facilities. Patients requiring toilet facilities could use the nearby ED. Information submitted following our inspection showed a 24-hour monitoring device was used to monitor the temperature and these were within the required range.

In response to the COVID-19 pandemic, changes were made to the layout of the urgent and emergency services. The Urgent Treatment Centre (UTC) had been moved out of the main ED and was now located in Clinic 9, which was some way away from the main emergency department. This meant patients arriving at the emergency department and referred to UTC would need to walk quite a distance to be treated. The Clinical Decision Unit had been closed to make way for the paediatric emergency department. Additional 'Red' patient waiting areas were made available. We found the footprint for urgent and emergency services did not allow for easy flow.

# Urgent and emergency services

All seven resuscitation cubicles had been refurbished to treat COVID-19 patients, as well as major trauma patients without risk of infection. All cubicles had glass doors with built in privacy curtains. This meant patients could be cared for in isolation, but staff could still see them in order to ensure their safety. All the rooms were negative pressure. A negative pressure isolation room is commonly used for patients with airborne infections.

The service had a designated children's area which maintained children's safety. At our last inspection, the paediatric area was not fully secure. Children accessed the main waiting area to access the paediatric area. At this inspection, we saw a dedicated separate paediatric emergency department was available with restricted access. However, the paediatric emergency department was not purpose built and therefore facilities, such as the waiting area and separate feeding area, were not adequate. The paediatric emergency department was also located quite away from the main emergency department. This meant children arriving at the main emergency department would need to walk quite a distance to be seen and treated either at the paediatric emergency department or UTC. The existing infrastructure did not permit treating all children in the paediatric emergency department and it was also difficult to move children to different areas.

The ED environment was no longer a sufficient size to accommodate the number of patients that attended. The extreme capacity pressure on the service had created greater challenges in using the environment for the purpose it was designed. The current infrastructure had an impact on significant crowding and the ability for consultants to provide clinical oversight of all areas of the department. The adult triage area was in the main entrance of the emergency department and there was no dedicated triage room. The adult waiting room was small which resulted in significant crowding and difficulty for patients to observe social distancing. Staff did their best to maintain privacy, but this did not stop patient consultations being overheard by other patients.

As with all emergency departments, the area was designed to accommodate patients for short periods of time while they were assessed and treated. However, due to capacity pressures, some patients had been in the department for long periods of time. Staff told us they did their best to meet patients' personal hygiene needs, but the facilities were not designed for patients to remain for long periods in the department.

Staff expressed concern with the emergency department frequently being overcrowded and patients waiting long periods to access beds. Staff gave an example of where an elderly lady sat on a waiting room chair for 12 hours overnight due to lack of trolley spaces and beds.

The trust had a designated room which was safe for patients attending the department with mental health crisis to use. Staff told us this was a protected space even when the department was busy. The room was ligature point free and had an accessible alarm system.

The service had suitable facilities to meet the needs of patients' families. The service had a family room which was available for staff to use when breaking bad news. The room was clean and clutter free in line with trust infection prevention and control guidelines.

Patients could reach call bells and staff responded quickly when called. During our inspection we noted patients had call bells where appropriate and staff answered call bells in a timely manner.

# Urgent and emergency services

An electronic system was available for staff to carry out daily and weekly safety checks of specialist equipment. All areas we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. However, daily and weekly checks were not always completed. Data provided by the service following our inspection showed between December 2021 and February 2022, daily checks were carried out on average 88%. For the same period, weekly checks were carried out on average 90%.

The maintenance and use of equipment kept patients safe. Electrical appliances and equipment had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show this had taken place. We checked 24 pieces of equipment and all were in date.

Staff disposed of clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Arrangements for control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards.

## Assessing and responding to patient risk

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

Systems were in place to assess risk, recognise and respond to deteriorating patients within the service. Systems were in place to appropriately assess and manage patients with mental health concerns.

Patients who self-presented at the ED were greeted by a streaming nurse. The nurse was an experienced registered nurse who took down a brief description of the presenting complaint and then directed the patient to the most appropriate service. Patients arriving by ambulance used a dedicated ambulance entrance and were triaged in one of the three rapid assessment and treatment (RAT) cubicles.

Nursing staff prioritised patients to be seen in order of clinical need and established if they were fit to sit in a chair to wait for treatment or if they required a trolley.

Hospital ambulance liaison officers (HALO) employed by a local NHS ambulance service worked alongside the ED team to support patient flow. This gave the opportunity to pre-alert staff if a patient required additional support and direct patient flow through the ED.

To ensure they were given appropriate care, patients were placed on relevant care pathways. This included patients with a fractured neck of femur, stroke or sepsis. The pathways were based on best practice guidance.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. The service used the early warning score system (NEWS2) for adults and paediatric early warning scores (PEWS) for children. An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. The use of an electronic system meant senior nursing and medical staff had oversight of the clinical risk of patients that were unwell.

NEWS2 and PEWS were monitored to a lower tolerance threshold within ED than it was within the wider hospital. Retrospective audit data for ED, therefore, was currently excluded from the trust wide reporting. The standards for vital signs monitoring within ED were as follows (PEWS scores were equivalent):

# Urgent and emergency services

- NEWS 0-4 - repeat vitals hourly
- NEWS 5-6 – repeat vitals every 30 minutes
- NEWS 7+ repeat vitals every 15 minutes (or continuous monitoring)

Compliance with these standards were supported with a “bell” system on the electronic patient record system, which was visible on the main tracking board screen, which appeared as an ‘amber’ bell when observations were due, and ‘red’ when the due time had passed.

Senior leaders told us that whilst compliance with NEWS2 and PEWS was regularly overseen by nurses in charge and the departmental matrons, the fact that this was not included routinely in retrospective audit data was a known gap and was subject to a change request for the electronic patient record system. The service had a plan going forward to report retrospective NEWS2/PEWS compliance alongside in-patient compliance data.

Staff used a triage tool to triage patients within 15 minutes of arrival to ED. During triage, staff completed initial observations, symptoms and professional judgement for all patients who were considered to need admission to ED. Data supplied by the service following inspection showed overall compliance against the 15-minute triage target between 19 December 2021 and 19 February 2022 was 93.9%.

Staff could monitor waiting times directly from the electronic patient record and escalate patients who were waiting too long to be seen.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening condition when the body’s response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff confidently described the signs of and what treatment should be initiated in line with national and local guidance. This included completing the ‘Sepsis Six’ pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner.

Audits were carried out to monitor compliance with the Sepsis Six bundle. Audit results from January 2022 showed Sepsis Six was delivered within 60 minutes in 53% of cases, against a trust target of 95%. For the same period, 67% of patients received antibiotics within one hour, against a trust target of 95%. The average compliance with the individual sepsis bundle elements was 90% for ED. The trust had a sepsis quality improvement project targeting areas identified as requiring improvement.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. Medical staff completed an initial admission assessment for patients, that included their presenting problem, past medical history and physical assessment. Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. We reviewed 12 sets of patient records and found all were completed, legible and risks were monitored routinely.

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 knew how to contact the mental health team when required and were aware this was a 24-hour service.



# Urgent and emergency services

Staff completed or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the mental health team should they have any concerns, and there was a timely response to assess patients.

Safety briefings took place twice a day and included discussion around staffing and skill mix. Appropriate actions were taken following the safety briefing and concerns escalated to senior staff.

Staff shared key information to keep patients safe when handing over their care to others. Staff participated in ward and board handovers where key information was shared at regular intervals throughout the day. This information included the patient's current wellbeing, any safeguarding issues, ongoing clinical needs and additional key information appropriate to the patients care.

## 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 efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.**

Due to national shortages of nursing and support staff and staff absence, the service did not always have enough nursing and support staff to keep patients safe. Staffing pressures were exacerbated by the pressures of the COVID-19 pandemic. The number of nurses and support staff did not always match the planned numbers.

Data provided by the service following our inspection showed between December 2021 and February 2022, there were on average 14.4% unfilled nursing shifts in adult ED, 9% in the emergency assessment unit (EAU) and 11.6% unfilled nursing shifts in the paediatric ED. It was recognised nationally there was an increase in absence across the health and care sector, particularly due to short term sickness.

Staffing levels impacted on patients' experiences. Staff told us the unit was often short staffed, some patients did not have timely access to treatment, and some patients left the department without being seen. Some staff we spoke with felt the workload was overwhelming and staff were feeling helpless.

Managers calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance. However, due to vacancy rates and sickness absence, the service did not always have enough nursing and support staff to meet the staffing numbers needed. Twice daily meetings enabled the staff team to identify any areas where staffing shortfalls occurred, and managers delegated staff accordingly. However, staff we spoke with told us, and we saw, staffing levels was on the risk register and recruitment was an ongoing challenge due to the nature of the workload in the ED and nursing in general.

Service leaders told us there was a strong recruitment pipeline in place for nurses. A careers carousel to promote access to nursing through apprenticeships took place in February 2022 with 40 new nursing apprentices appointed trust wide. As well as increasing nursing apprenticeship numbers, work was underway with regional education providers to develop more apprenticeship models.

ED managers could adjust staffing levels daily according to the needs of patients. There was an established escalation and mitigation procedure in place for managers to raise staffing issues and concerns. Additional staffing requirements were discussed with the wider management team throughout the day at site meetings.



# Urgent and emergency services

The service used bank and agency staff to meet planned staffing numbers. Internal bank and agency staff were offered unfilled shifts to ensure staffing establishment was met, where possible. Staff told us the bank staff used were generally the same staff and were known to the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Data provided by the trust following our inspection showed in the three months leading to February 2022, agency nurses covered just over 3% of shifts.

All nursing staff working in the paediatric emergency department were registered children's nurses.

Data shared by the trust following our inspection showed 89% of ED registered nurses (RN) were compliant with immediate life support (ILS) and 70% paediatric immediate life support (PLS), against a trust target of 90%.

## 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. Managers regularly reviewed staffing levels and skill mix, however, this did not always provide established levels of staffing.**

The service did not always have enough medical staff to keep patients safe. The emergency department had an agreed establishment of 23.7 whole time equivalent (WTE) consultant medical staff. The service were fully recruited against this and had an additional two locum consultants agreed to ensure the rota was filled. A service review was ongoing and ED had proposed a five year recruitment plan which, if accepted, would increase the establishment. Consultant cover was in line with the Royal College of Emergency Medicine guidelines from 8am to 3am daily with on call cover outside of these hours. Four paediatric emergency medicine (PEM) trained consultants were also in post. However, consultant cover was not in line with Major Trauma Centre Service specification which recommends 24-hour onsite consultant cover for services with a major trauma centre. This was listed as a risk on the services' risk register. The trust continued to work with staff and commissioners to provide a 24-hour emergency medicine consultant presence. It was recognised this would be a gradual and phased process due to the availability of the workforce.

Data provided by the service following our inspection showed for the month of February 2022, there were nine clinical and four administrative (results checking and patient feedback) gaps in the consultant medical rota. Most of these were voluntarily covered by other consultants to fully cover the rota. There were two shifts in February 2022 that were not fully covered.

On the day of our inspection, most of the medical staff we spoke with expressed concerns with staffing levels. Senior medical staff felt it was difficult to provide oversight to all areas within urgent and emergency care with the current number of consultants available. They felt reduced staffing, in conjunction with increased workload, had contributed to the decrease in flow through the ED. On the day of our inspection, there were seven senior medical staff on sick leave. Three consultants who were not scheduled for duty came in to cover the gaps.

Staff we spoke with during our inspection told us medical staff often worked over their allotted hours to provide ongoing support to patients and staff and to ensure there were enough senior clinical decision makers available for patients. They generally felt there were not sufficient numbers of medical staff to meet current demands of the service.

# Urgent and emergency services

Managers could access locums when they needed additional medical staff. Data supplied by the trust following our inspection showed that in February 2022, locum cover was requested for 170 shifts, of which 131 were filled (77%). Locum staff were given a full induction before commencing duties.

Data shared by the trust following our inspection showed 31% of relevant ED medical staff held a current advanced life support (ALS) qualification and 19% held advanced paediatric life support (APLS) qualification, against a trust target of 90%. The trust told us that during the pandemic face to face training was paused. However, actions were in place to increase compliance rates which were improving as the trust returned to recovery.

All junior medical staff we spoke with said they received a good level of support from their consultants who were approachable and able to be contacted at any time. Junior doctors reported they had been allocated an educational supervisor and clinical supervisor.

## 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.**

Patient notes were comprehensive and all staff could access them easily. The service used an electronic patient record system. All nursing and medical staff had received training in using the system. Staff we spoke with felt confident in using the system.

Records were stored securely and confidentially on the electronic system.

We reviewed 12 electronic patient records. All the records we reviewed contained details of patients' presenting conditions, medical history, relevant care plans and observations. We observed that risk assessments were fully completed in all the records we reviewed.

## 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 planned 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 planned and organised services so they could meet the changing needs of the local population. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. The service worked collaboratively with external agencies and partner organisations to improve services provided by the trust. This included working with the clinical commissioners, general practices and neighbouring NHS trusts to identify the needs for the local community.

# Urgent and emergency services

The trust worked with six other trusts across the region, and the NHS England/Improvement regional teams, to develop a Specialised Services Provider Collaborative. The trust had commenced clinical engagement to identify current and potential future areas for collaboration, analysing the best opportunities to expand capacity within the region to add resilience to local services and support local access for patients, and building greater capacity to plan and implement change over the coming years. The trust was recruiting a project team to accelerate this work, who would work in partnership with a virtual team from across the other providers.

The trust ensured patients were seen by the most appropriate professional. The service provided a streaming nurse at the front door to the ED. This was a role carried out by an experienced nurse and involved obtaining a brief history from the patient and then navigating them to the most appropriate service in the hospital such as the urgent treatment centre or ambulatory care.

The service ensured patients had a clear understanding of alternatives to the ED to have their care needs addressed. The trust used their website and social media platforms to provide information to patients about the alternatives to attending ED and to encourage self-help, such as attending their local pharmacy or using the NHS 111 service.

The service relieved pressure on other departments when they could treat patients in a day. The urgent treatment centre (UTC) worked to provide GP services and a range of treatments for minor illness and injuries in order to reduce hospital admissions. Same day emergency care pathways were also in place to reduce hospital admissions.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health conditions, learning disabilities and dementia. The service worked well with local teams embedding a pathway to care for patients living with a mental health condition or a learning disability.

## Access and flow

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

Data from NHS England accident and emergency Attendances and Emergency Admissions showed there was a considerable increase in type one accident and emergency attendances over the course of 2021, from 5,447 in January to 10,111 in October. This was followed by a reduction to 8,827 in December. The overall trend was broadly in line with most other trusts in the East of England region. The proportion of the trust's type one accident and emergency attendances that were majors was consistently lower than the East of England and England averages from 17 October 2021 to 6 February 2022.

The trust also saw a considerable increase in type three attendances over the course of 2021, from 1,613 in February to 5,636 in July. This was followed by a reduction to 4,492 in December. The overall trend was broadly in line with most other trusts in the East of England region. A type one attendance is 'major' and the patient may require full resuscitation facilities. A type three attendance is for more minor injuries or illness.

Managers monitored waiting times and adapted services to support patients' access to emergency services. However, not all patients received treatment within agreed timeframes and national targets due to significant strain on capacity. The infrastructure of the emergency department, together with longer stays for patients in ED, meant there was poor patient flow out of the department leading to significant delays in patients waiting to be seen and moving from the ED to the wards.

# Urgent and emergency services

The trust was one of the participants in the clinically led review of NHS access standards. As such, the trust submitted no data for the four-hour national target for either type one or type three accident and emergency attendances from January 2020 to December 2021.

Time to treatment for type one attendances is defined as time from arrival at the emergency department to the time when a patient is seen by a decision-making clinician (someone who can define the management plan and discharge the patient) to diagnose the problem and arrange or start definitive treatment as necessary. The trust's median time to treatment was consistently longer than the 60-minute standard and England average from April 2021 onwards. Between 17 October 2021 to 6 February 2022, the percentage of patients receiving treatment within 60 minutes at the trust was 28.2%. This compared with England performance of 35.6% and East of England performance of 39.0%.

From 17 October 2021 to 6 February 2022, the proportion of the trusts' ambulance attendances waiting from between 30 and 60 minutes to handover was quite variable compared to the regional and England averages. The proportion waiting over 60 minutes to handover was mainly lower than the regional and England averages.

There was a separate entrance for patients arriving by ambulance. The service had a rapid assessment and treatment (RAT) which included three cubicles. Whilst the service aimed to use this area for rapid assessment and treatment (ideally within 30 minutes), we noted during our inspection one patient had been in RAT for two hours due to capacity and access to other areas of the hospital.

Managers and staff started planning each patient's discharge as early as possible, but some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge. The trust's median total time in ED for admitted patients was consistently among the longest in the East of England region over the 24 months from December 2019 to November 2021. In January 2022, 785 patients had an ED journey time in excess of 12 hours. Staff told us there were often delays in finding beds once the decision to admit (DTA) had been made. Patients were waiting for extended periods within the ED due to the wider hospital capacity issues. We found engagement from staff varied between different specialties and sub-specialties. Some specialties, such as the stroke team, were engaged with improving patient flow, whilst other more general specialties were not so engaged.

The trust's median total time in ED for non-admitted patients was generally among the lowest in the East of England region from June 2020 onwards.

From June to December 2021 the number of patients waiting over 12 hours from the decision to admit to admission at the trust was among the highest in the East of England region. In December 2021, the trust reported 41 patients waiting more than 12 hours and in January 2022, 143 patients had waited more than 12 hours from the decision to admit.

At 2pm during the inspection there were 133 patients in the ED, of these, 17 patients had already had decisions to admit and were waiting for beds on wards. This meant staff were not always able to accommodate new patients arriving in the department. The mean (average) time to be seen by a doctor on the day of our inspection was 459.98 minutes.

Staff discussed ED safety and quality issues, staffing, patients with decisions to admit capacity, ambulance offload delays and mental health assessment delays as part of their regular safety huddles. ED service leads escalated concerns around flow to the site meetings which were held four times a day. We attended the 11am site meeting, which was multidisciplinary. Staff from each service shared a report of their current situation. This included bed occupancy numbers, number of patients who could potentially be discharged and number of patients waiting to go to a ward.

# Urgent and emergency services

Senior leaders recognised the increased attendance had placed additional pressure on the ED, resulting in significant crowding in the department and long waits. They recognised effective triage, discharge processes, escalation and improved flow within the hospital were key to addressing these challenges and work was underway with teams across the trust to help support this work. The trust continued to closely monitor challenges for patients and staff in the emergency pathway, and to implement further plans. A pilot was underway to test the use of a dedicated transfer team to provide a patient transfer service from the short stay units and the ED to the trust's wards, to ascertain whether it improved patient flow out of these areas, thereby reducing the number of patients who waited more than six and 12 hours. Phase three of the GP liaison test of change commenced on 29 November 2021, whereby consultants provided advice to GPs, Monday to Friday, 9am to 5pm. As at 23 February 2022, following consultant advice, 627 patients were sent to ED, 864 to same day emergency care (SDEC) and 163 patients were kept at home; therefore, 62% of patients who would have previously attended the ED, were seen elsewhere, or did not attend. A business case was in development, as the current funding for this service was due to end on 31 March 2022.

A further improvement project which was in the planning phase, to improve UEC patient flow, was looking at reviewing patients with post-operative trauma and orthopaedic problems by a specialist clinic nurse, to test whether these patients could bypass the ED.

A number of medical assessment areas and transit wards had been created to increase capacity. In addition, the resuscitation cubicles were refurbished to accommodate patients on both red and green pathways.

## Is the service well-led?

**Inspected but not rated** ●

We inspected but did not rate well led.

### 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 departments at the trust were grouped together under five divisions. The urgent and emergency care department was part of Division C. There was an established leadership structure within the division. The senior leadership team included a divisional director, an associate director of operations and a divisional head of nursing. They were supported by the local leadership team including the clinical director for ED, deputy head of nursing and the operations manager for ED.

We observed effective leadership in the department. The emergency practitioner in charge, the nurse in charge, and operations manager provided good leadership and we observed strong teamwork within the department. They retained oversight of demand and capacity in the department. Staff told us the emergency department leadership team were very visible, accessible and approachable to their staff and others.

Staff we spoke with told us managers were visible within the department providing day-to-day support and managers worked closely with them to manage patient care. However, staff described a culture of being overwhelmed by the number patients and improvements in patient flow were slow to happen.

# Urgent and emergency services

We met with the senior leadership team (SLT) who spoke with pride about the work and care their staff delivered on a daily basis. The team demonstrated an awareness of the service's performance and the challenges they faced. However, the team recognised further actions were needed to address the challenges.

Senior leaders were involved on a day to day basis, to support a safe and effective approach to clinical staffing and patient flow. However, this was challenging given the pressure the service was facing. Senior leaders had a thorough understanding of the improvements that were needed to strengthen the quality of their service. They understood the challenges to quality and sustainability the urgent and emergency service faced and had pro-active ongoing action plans in place to address them. This included working collaboratively with a number of partners, both internal and external, to lead on a programme of work designed to provide improvements in flow across the hospital. The trust was part of the South Integrated Care Partnership (part of the Integrated Care System) who were collaboratively working on system resilience development programmes (including patient flow). Part of the programme was establishing a Community Care Coordination Hub to provide proactive support for patients discharged from hospital, or who need urgent care in the community to reduce the need for them to attend the ED.

Other initiatives to improve the flow included strengthening same day emergency care (SDEC) pathways with pre-hospital support. A number of pre-hospital admission/attendance avoidance actions had been put in place. The GP liaison line had a material impact, as had other similar services, such as advice to GPs from surgeons, NHS111 redirection, minor injuries video support, streaming at front door to SDEC/ UTC/ back to Primary Care and NHS111. Senior leaders told us the most impactful had been the GP Liaison pilot. This line, staffed by ED consultants, was initially three days a week. As a result of its success this was expanded to five days a week. As a result, 21% of calls to the line resulted in patients being kept at home and 58% were referred into SDEC pathways, with the remainder appropriately attending ED. A case to make this a substantive service had been made through budget setting for 2022/23.

Leaders were supportive of staff development and staff we spoke to told us there were a number of internal and external leadership programmes available to them.

## Culture

**Staff felt respected, supported and valued by the local leadership team. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

During our inspection the ED teams described working at their full capacity, with the feeling of being overwhelmed with the increased demand on the service and continuous crowding within the department. However, staff were positive about working in the department and explained there was strong teamwork and how the department felt like a family. We observed a strong cohesive team within the department. Staff told us they felt respected, supported and valued by their local leadership team, however, some staff told us there was lack of communication and support from the executive leadership team.

All the junior doctors we spoke with told us they enjoyed working in the ED, they said they felt supported and valued by their seniors and colleagues and that they had opportunities to learn and gain confidence. Staff told us there were good training and support mechanisms in place for junior doctors. All junior doctors spoke very positively about their training and supervision.

# Urgent and emergency services

An open culture was promoted within the department to ensure staff, patients and their families could raise concerns. Staff explained how they were able to raise concerns with their immediate line managers and felt able to speak freely. A team of 'ED Listeners' was also in place which included staff of varying grades and disciplines who were available to listen to anyone wanting to raise a concern or talk about issues which was difficult to do through other channels.

Patients could leave feedback in several ways, including through local and national patient surveys, friends and family tests, through the patient advice and liaisons service (PALS) and by social media.

## 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.**

There were clear assurance systems in place, and performance issues were escalated appropriately through established structures and processes. There were processes to manage current and future performance, which were regularly reviewed at specialty and divisional meetings. There was a systematic programme of clinical and internal audit to monitor quality, and systems were in place to identify where action should be taken.

The service had arrangements in place for identifying, recording and managing risks. The division had a risk register which included a description of each risk, an assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring. The risk register was monitored within the governance framework and regularly reviewed.

Key quality performance indicators were measured and reported monthly to the trust board. They covered a wide range of quality indicators, including infection control indicators, incidents, time to treatment and initial assessment, ambulance handover delays, 12-hour trolley waits, complaints, and friends and family test results.

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible.

Escalation processes were embedded within the service to deal with increased demand, the challenge of the wider hospital capacity issues and the impact of delayed waits on patients remained a significant concern for the ED service.

There were regular staff meetings to share learning from incidents and complaints. Where specific actions were required, they were fed back at daily handovers and safety briefings.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

## Areas for improvement

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

### Action the trust **MUST** take to improve:



# Urgent and emergency services

- The service must review the current infrastructure of urgent and emergency services to ensure the design and use of facilities and premises keep people safe. (Regulation 15 (1) (c) (f))
- The service must ensure staffing levels for nursing and medical staff are adequate to meet demand. (Regulation 18 (1))
- The service must ensure staff are up to date with the appropriate level of life support training. (Regulation 18 (2))
- The service must ensure patients receive treatment in a timely way; ensure patients are cared for, at all times (including overnight) in areas designed for this purpose; and with the facilities, clinical and otherwise, which meet their needs. The trust must ensure patients do not experience long waits and are admitted, if necessary, from the emergency department to a ward bed in a timely way; and have a timely response from specialty doctors to assess emergency department patients in line with the agreed protocol. (Regulation 12 (1) (2) (a) (b) (d))

## **Action the trust SHOULD take to improve:**

- The service should ensure safeguarding training amongst nursing and medical staff is completed in line with trust targets. (Regulation 13)
- The service should ensure daily and weekly checks on resuscitation equipment is maintained in line with trust guidance. (Regulation 12)
- The service should ensure compliance with the Sepsis Six Bundle improves. (Regulation 12)