Nottingham University Hospitals NHS Trust

Queen's Medical Centre

Quality Report

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Date of inspection visit: 7, 8 & 11 December 2016
Date of publication: 23/02/2017

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

This inspection was a focussed, responsive, unannounced inspection looking only at the adult emergency department and the short stay observational ward (Lyn Jarrett Unit). We did not inspect the children's emergency department, the major trauma centre or the eye casualty. We inspected this service because of concerns about the trust's performance against the four hour waiting time standard for emergency departments.

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and information given to us from patients, the public and other organisations.

Our key findings were as follows:

- Patients did not have timely access to initial assessment and diagnosis.
- There was a risk that high demand, unrelenting pressure and staff perception that they were providing a poor service would lead to a demoralised culture and a lack of service sustainability.
- Call bells were not available in the majors cubicles and there was insufficient seating for patients waiting in reception and for relatives in the majors and resuscitation areas.
- Staff did not always assess and respond to patient risks appropriately whilst they were waiting to be seen in the department but leaders responded swiftly to address and mitigate these risks when we brought them to their attention.
- Ongoing issues with the implementation of a new computer system meant staff did not always have the information they needed to deliver effective care.
- The overcrowding in the department made it difficult for staff to protect the privacy and dignity of patients.

However:

- People were protected from avoidable harm and abuse. There was a good track record on safety. Standards of cleanliness and hygiene were generally well maintained, staff received effective mandatory training and there were appropriate nursing and medical staffing arrangements.
- People's care and treatment achieved good outcomes and was based on the best available evidence with staff, teams and services working together effectively. Patients' pain was assessed and managed appropriately and they were given drinks and where appropriate food. Staff were given the skills and knowledge to deliver effective care and treatment and there was an ethos of continual learning in the department.
- Despite the overcrowding in the department staff cared for patients with compassion, patience and kindness.
- Services were planned and delivered to meet the needs of local people and individuals. People's concerns and complaints were responded to and used to improve the quality of care.
- Leadership, governance and culture were used to drive and improve the delivery of sustainable, high quality person-centred care. There was a supportive culture focussed on continuous learning with strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.

We saw some outstanding practice including:

- Nursing handovers, called 'roll call' took place in the emergency department at 7am and 7pm. All qualified and unqualified nursing staff attended. They were shown an electronic presentation of information including themes of complaints and any changes to practice. The outgoing nurse in charge gave information about the previous shift,

patients in the department, cleaning and stock levels. A member of the department for research and education in emergency medicine, acute medicine and major trauma (DREEAM) team also attended to deliver short teaching sessions as appropriate. This staff member would also ensure agency staff had received an induction to the department which was recorded.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Queen's Medical Centre

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Background to Queen's Medical Centre

Queen's Medical Centre is an acute teaching hospital and is part of Nottingham University Hospitals Trust. The trust provides services to a population of more that 2.5 million people in Nottingham and its surrounding communities.

The Queen's Medical Centre adult emergency department and short stay observational unit were inspected during unannounced visits on 7, 8 and 11 December 2016.

The inspection was a focussed, responsive, unannounced inspection. We inspected the adult emergency department and short stay observational unit because of concerns about the trust's performance against the four hour waiting time standard for emergency departments. The service was previously rated as good overall, with well led rated as outstanding. For the purposes of this inspection we did not inspect the children's emergency department, the major trauma centre or the eye casualty unit.

Our inspection team

Head of Hospital Inspection: Carolyn Jenkinson.

Our inspection team was led by: Helen Vine, Inspection Manager.

The inspection team included three CQC inspectors, an inspection planner, an A&E consultant, a clinical manager and a paramedic operations manager.

How we carried out this inspection

Before our inspection we reviewed a range of information about the emergency department at Queen's Medical Centre.

During the inspection we spoke with patients, relatives or carers and a range of staff including doctors, nurses, allied health professionals, administrative and housekeeping staff, volunteers, senior managers and non-trust staff including police officers, ambulance crews and security staff.

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	**Requires improvement**

Information about the service

The Emergency Department at Nottingham University Hospital, Queens Medical Centre provides consultant led emergency care and treatment 24 hours a day, seven days a week. There is a separate co-located children's emergency department which was not included in this inspection. Between November 2015 and October 2016, 130,588 adult patients attended the adult emergency department. This was an average increase of 4% compared with attendances of 125,216 for the previous 12 month period. The trust predicts a further 3.7% increase in patient attendances for the year November 2016 – November 2017. The numbers of patients attending the department is consistently higher than the capacity for which it was designed.

The emergency department and acute medicine team share a 20 bedded short observational stay ward called the Lyn Jarrett Unit. This is where patients can be admitted under an emergency or medical consultant for short term observation up to 24 hours.

During our inspection with spoke with 18 patients, five relatives or carers, 54 staff members, and 13 non-trust staff, for example ambulance crews, police officers, security staff and volunteers. We looked at eight records of care and treatment. As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us.

We visited the reception and waiting areas, ambulance bay, initial assessment areas, ambulatory care (green team), minors (yellow team), majors (blue team) and resuscitation area (red team), relatives' rooms, plaster room and the short stay observation ward.

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Urgent and emergency services

Summary of findings

We rated this service as requires improvement because:

- Patients did not have timely access to initial assessment and diagnosis.
- There was a risk that high demand, unrelenting pressure and staff perception that they were providing a poor service would lead to a demoralised culture and a lack of service sustainability.
- Call bells were not available in the majors cubicles and there was insufficient seating for patients waiting in reception and for relatives in the majors and resuscitation areas.
- Staff did not always assess and respond to patient risks appropriately whilst they were waiting to be seen in the department but leaders responded swiftly to address and mitigate these risks when we brought them to their attention.
- Ongoing issues with the implementation of a new computer system meant staff did not always have the information they needed to deliver effective care.
- The overcrowding in the department made it difficult for staff to protect the privacy and dignity of patients.
- Whilst there was inspirational leadership on the ground in the department the trust board had yet been unable to find a solution to the overcrowding.

However:

- People were protected from avoidable harm and abuse. There was a good track record on safety. Standards of cleanliness and hygiene were generally well maintained, staff received effective mandatory training and there were appropriate nursing and medical staffing arrangements.
- People's care and treatment achieved good outcomes and was based on the best available evidence with staff, teams and services working together effectively. Patients' pain was assessed and managed appropriately and they were given drinks and where appropriate food. Staff were given the skills and knowledge to deliver effective care and treatment and there was an ethos of continual learning in the department.
- Despite the overcrowding in the department staff cared for patients with compassion, patience and kindness.
- Services were planned and delivered to meet the needs of local people and individuals. People's concerns and complaints were responded to and used to improve the quality of care.
- Leadership, governance and culture were used to drive and improve the delivery of sustainable, high quality person-centred care. There was a supportive culture focussed on continuous learning with strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- Patients did not have timely access to streaming, and initial assessment.
- Whilst some staff spoke with confidence about how they would report faulty medical equipment we could not be assured there was a safe and effective system in place for the repair and maintenance of other equipment.
- Call bells were not available in the majors cubicles.
- Staff did not always assess and respond to patient risks appropriately whilst they were waiting to be seen in the department but leaders responded swiftly to address and mitigate these risks when we brought them to their attention.

However:

- There was a good track record on safety. Lessons were learnt and improvements made when things went wrong.
- Standards of cleanliness and hygiene were generally well maintained.
- Medicines including controlled drugs were stored, managed, administered and recorded safely and appropriately.
- People's individual care records were recorded and managed safely. Arrangements were in place to safeguard vulnerable adults from abuse.
- Staff received effective mandatory training.
- There were appropriate nursing and medical staffing arrangements.
- Major incident and business continuity plans were in place and staff understood their roles and responsibilities.

Incidents

- Staff understood their responsibilities to raise concerns and to report safety incidents internally and externally. Staff at all levels received feedback from incidents via the roll call (handover) presentation.
- There were seven serious incidents reported between November 2015 and November 2016. The trust referred to these as higher level incidents (HLIs). Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response. Thorough investigations were carried out into these incidents and people affected were kept informed, given an apology and advised what actions would be taken as a result of investigations. Lessons were learnt and actions taken following incidents. Minutes of the September clinical governance meeting showed there were 227 incidents still open for investigation with some dating back to 2015. There was a plan to address this backlog.
- There were no never events reported for the period November 2015 to October 2016. Never Events are serious incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.
- The department held monthly mortality and morbidity meetings. We saw evidence that learning from those meetings was shared with staff. Mortality and morbidity meetings are used in emergency departments to review deaths and learn from them.
- For adults receiving intravenous fluid therapy in the emergency department clear incidents of fluid mismanagement were reported as serious incidents as required by National Institute of Care Excellence (NICE) guidelines SQ66 statement 4.
- Staff were aware of their responsibilities under the duty of candour regulation. This legislation requires that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the person that the incident has occurred provide reasonable support to the relevant person in relation to the incident and offer an apology. We saw evidence of staff having provided written apologies when things went wrong.

Cleanliness, infection control and hygiene

- The adult emergency department was visibly clean for the majority of the time during our inspection; however, keeping areas clean was a challenge with the number of patients in the department. Areas were rarely clear or empty for cleaning to take place but when they were we saw staff taking the opportunity to do so. Cleaning audits for September, October and November 2016 showed results of 64%, 74% and 48% respectively. The

trust were taking action to address the concerns they had identified around the quality of cleaning carried out by the sub-contracted service. This risk was on the departmental risk register.

- Staff were aware of and practised current infection prevention control guidelines. Adequate hand washing facilities and alcohol gel were available and staff were observed washing their hands appropriately. They followed bare below the elbow guidance and used personal protective equipment such as gloves and aprons to prevent the spread of infection. The department audited hand hygiene and results for the months of August and November 2016 ranged between 83% for doctors in August to 100% for allied health professionals for both months..
- There were zero reported cases of Methicillin-resistant Staphylococcus Aureus (MRSA). MRSA is a type of bacterial infection and is resistant to many antibiotics.
- There were zero reported cases of clostridium difficile (C.difficile) infections. C.Difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics and has the capability of causing harm to patients.
- Clinical and domestic waste was separated and disposed of correctly. This included sharps such as needles. However we did observe five bags of clinical waste on the floor in the resuscitation department sluice room.
- The emergency department had a decontamination room which was used appropriately and cleaned according to procedure.
- Although curtains in the department were not disposable, there was a regular cleaning and replacement schedule. Soiled curtains were removed and replaced immediately.
- People who needed a urinary catheter inserted had their risk of infection minimised because staff followed guidance in NICE QS61 statement 4.
- People who needed a vascular access device had their risk of infection minimised because staff followed guidance in NICE QS61 statement 5.

Environment and equipment

- Whilst some staff spoke with confidence about how they would report faulty medical equipment we could not be assured there was a safe and effective system in place for the repair and maintenance of equipment. We found a sluice handle in the resuscitation area was broken. It was taped up and labelled as out of use, however the sluice was still being used. The nurse in charge told us the fault had been reported but we could not find a record of this in the folder used to log faulty equipment. Chairs in the reception area and in the minors waiting area were ripped and the nurse in charge confirmed these had not been reported. There was some confusion amongst staff as to where and how these should be reported. When we returned to the department later we checked the log and the chairs were not listed as having been reported. Staff told us conflicting information about logs for equipment faults as some said there were two logs; one behind reception and one in the sisters' office. Other staff when asked were only able to tell us of the log behind reception. There was a lack of clarity about the process for reporting estates issues compared with medical equipment issues.
- We noticed staff in the initial assessment unit using clinical waste bins to lean on for notes and as a place to rest treatment trays as there were no other surfaces in these areas. This could be an infection risk. Patients and relatives in the resuscitation area were also using clinical and domestic waste bins to rest food and drinks on as there were no other available surfaces.
- Call bells were not available in the majors cubicles. The majority of cubicles were visible from the nurses' desk and staff told us they would only put mobile or accompanied patients in these bays. However, during our inspection we observed one patient's relative raising the alarm for another patient in one of these cubicles who was struggling to get out of bed. This patient had sustained a head injury but was not visible to the nurses' station. Staff responded immediately, however, with large numbers of patients there was a risk patients may not be able to call for help when they needed it and were out of sight of staff. Some senior nurses told us they were concerned about the lack of visibility of these cubicles.
- Heart monitoring equipment was enabled in the initial assessment unit however the printer port was not so staff were having to leave the area to retrieve print outs. The department had purchased the necessary wiring in December 2014 and were still waiting for a contractor to carry out the work.

- Two dedicated, appropriately equipped interview rooms were available in the emergency department for patients with mental health conditions. These areas complied with the requirements of Health Building Note 15:01.
- There were adequate supplies of available, accessible and suitable equipment, including resuscitation equipment. There was a schedule for regular checks for equipment which had been followed and recorded in all areas we inspected.
- The layout of the department was appropriate for supporting easy access to diagnostic and imaging services as well as theatres.

Medicines

- Medicines including controlled drugs were stored, managed, administered and recorded safely and appropriately. All areas we visited used an electronic storage system for medication which was activated by staff finger prints. Agency staff working in the department were provided with a temporary access code for the medication storage system.
- Qualified nurses in the Initial Assessment Unit (IAU) were working under a patient group direction (PGD) for the prescription and administration of simple pain relief. Patient group directions provide a legal framework that allows some registered health professionals to supply and or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- On LJU patients' own medications were stored in a locked cabinet in a slot relating to the bed they occupied. Where appropriate patients were encouraged and supported to manage their own medicine administration.
- Patients were prescribed antibiotics in accordance with local antimicrobial guidelines.
- Audit data supplied by the department showed allergies were documented appropriately in 76% of patient records reviewed.

Records

- Staff accessed patient records electronically and computers not in use were locked to protect patient confidentiality. A new computer system had been introduced to the department in the summer of 2016. Medication records were paper based.
- We looked at eight records of patient care which were all completed according to the requirements of the trust's policy. Appropriate risk assessments had been completed, for example sepsis screening and safeguarding questions.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns. There was a departmental safeguarding champion. Medical staff completion rates for level three safeguarding training were 91%. This training included female genital mutilation (FGM) and child sexual exploitation (CSE). Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons.
- Staff were aware of the trust's specialist domestic abuse nurses and how to make referrals. Recent team days had included training delivered by this nurse.
- Staff in the adult emergency department shared information about children at risk who were not patients but part of a family unit where an adult at risk had attended the department.

Mandatory training

- Mandatory training completion rates for nursing and medical staff were 86%.
- Nursing training completion rates for hospital life support training were 91% with an additional 28% of nursing staff having completed advanced life support training.
- There was a policy for sepsis management and staff were aware of it. Eighty nine staff had received specific training in sepsis management.

Assessing and responding to patient risk

- Patients did not have timely access to initial assessment. Between November 2015 and November 2016 the average time to initial assessment of patients in the department was 33 minutes with the shortest waiting time of 28 minutes and the longest of 91 minutes. Department of Health guidelines state patients should receive an initial assessment within 15 minutes of arrival.
- During the early part of our inspection we raised concerns about the safety of patients waiting to be seen by a streaming nurse after they had booked in at the reception. Streaming nurses carry out an initial

assessment of patients so they can be streamed to the most appropriate care and prioritised according to their illness or injury. We observed patients that were unwell and we alerted staff to a patient who had collapsed. Streaming staff were seeing patients according to arrival times and not according to the priority of their medical need.

- On our unannounced visit to the department several days later a senior nurse told us about the changes they had made to ensure patients were visible to staff during their wait. The reception staff told us they observed the patients and we saw them doing this during the second part of our inspection. However, staff did acknowledge that when the department was exceptionally busy they were less likely to be able to observe patients because they were constantly booking patients into the department. The department had also introduced an escalation system so that the nurse in charge was informed if there were more than 12 patients waiting for streaming or patients were waiting longer than 30 minutes. Any patients presenting with an illness were being asked to wait on the first two rows of chairs in the minors department. Whilst this meant they were facing away from the minors desk they were visible to staff there and to staff in the second streaming room.
- Leaders in the department told us they had recognised that the streaming process could work more effectively. There was a proposal to change to a single front door model very soon after our inspection. This would involve primary care partners in assessing patients on arrival and diverting some to more appropriate pathways for care and treatment. Streaming training had been provided to emergency nurse practitioners (ENPs).
- However during a period of lengthy waits when only one streaming room was being used we observed staff calling patients to streaming by arrival time rather than clinical priority. This showed a lack of regard to risk. Following our inspection we wrote to the trust requesting more information about how they were reducing the risk to patient safety for those patients waiting for streaming. The trust responded with a comprehensive range of actions which they had immediately implemented including: a new escalation tool to ensure a reduction to safe waiting times, a relocation of the waiting area into the minors area where patients would be more visible to nursing staff, changing staffing arrangements for the streaming team and providing nurses with additional training. There was also a plan for emergency department assistants (EDAs) to perform clinical observations on all patients who had been waiting for longer than 30 minutes for streaming. The department had developed a plan with the department of research and education in emergency medicine, acute medicine and major trauma (DREEAM) for an official training package for EDAs in recognising unwell patients. This training would include clear guidance on which patients to escalate for immediate streaming when they booked in. We were assured that the risks we had identified had been responded to and swiftly mitigated.
- As a result of the numbers of patients in the department many patients were waiting in the central area of majors on hospital trolleys as there were not enough cubicles to accommodate all patients. These patients were waiting for assessment, tests or treatment. We raised concerns that these patients may not be receiving the same level of observation and care as other patients in cubicles. There was an emergency department assistant (EDA) allocated to this group of patients. Their role was to observe and respond to any requests for support or information. However, during our inspection we saw that some of these patients were not receiving clinical observations at the required frequency and we were concerned there were no clinical staff allocated to check that these patients were not deteriorating. We raised these concerns with the head of service. When we returned to the department for a later visit the nurse in charge told us of the actions they had taken to address these concerns. The majors team had increased from two to three teams of nursing staff with one registered nurse allocated to care for patients in the central area. The department had reviewed their internal escalation policy to ensure a more immediate response should the resuscitation area become full. We were assured that the risks we had identified had been responded to and mitigated swiftly.
- The percentage of ambulances remaining at the hospital for more than 60 minutes had increased from zero to 9.9% between October 2015 and October 2016. The England average for this indicator was 6.9%. During the period April to November 2015 the department was considered to be demonstrating best practice because of the number of patient arrivals it was able to manage with an average pre-handover time of less than 19

minutes. However at the time of our inspection pre-handover times were just under 25 minutes. The increase in patient numbers equated to approximately 3%.

- For the eleven months from November 2015 to the end of October 2016, 38,410 patients arriving by ambulance waited longer than 15 minutes to be handed over from the care of the ambulance crew to the care of hospital staff. Patients waiting more than 30 minutes totalled 14,084 and more than 60 minutes 1231. Patients waiting for 60 minutes would also be counted in the figures for 30 and 15 minute waits and patients waiting for 30 minutes would also be counted in the 15 minutes wait figures. There were on average around 59,000 patients arriving at the emergency department by ambulance in each 12 month period.
- The service improvement lead and a senior nurse were working on a project to improve ambulance handover times. However, they told us they were struggling to get engagement from the local ambulance trust leadership to support improvement actions. There was a plan to install a system to alert ambulance crews to an available cubicle in the initial assessment unit. This was because crews had become so accustomed to waiting in the corridor there were occasions when they were waiting unnecessarily.
- There had been 1230 black breaches in the 12 months prior to our inspection. A black breach is where a patient has waited on an emergency department trolley for more than 60 minutes to be handed over from the care of an ambulance crew to hospital staff.
- There was an initial assessment unit (IAU) operating in the adult emergency department 24 hours a day, seven days a week. All patients arriving by ambulance, except those going straight into the resuscitation area were seen first in the IAU. All patients arriving independently and assessed as having a major injury or illness were also sent to the IAU by streaming nurses. Nurse led investigations took place immediately and an advanced nurse practitioner (ANP) or middle grade doctor was available in the area between 10am and 2am to support decisions. A board with pathway posters and protocols was available in the unit so staff were able to standardise the initial assessment of patients. These protocols were based on the Royal College of Emergency Medicine (RCEM) guidelines.
- There was a system in place to monitor risk to patients. Staff in the adult emergency department used a recognised early warning score tool (EWS). Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- There was clear evidence of the use of a sepsis bundle for the management of sepsis. For the period June to November 2016, 80% of patients presenting with sepsis were given antibiotics within one hour. Sepsis is a severe infection, which spreads in the bloodstream. The full sepsis bundle was delivered to 62% of patients. The trust audited the care of every patient requiring admission to critical care as a direct result of severe sepsis and an individual clinician feedback report was sent to every clinician identified in the notes involved with each patient during the period of sepsis, to reinforce learning and positive actions. The sepsis bundle is a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis. Eighty nine staff had received specific sepsis training.
- Escalation procedures were in place for the adult emergency department with normal levels of demand being rated green, and increasing levels rated amber, red or black with black being the most severe. We saw these processes operating effectively during our inspection. The trust had been operating consistently at red and this had become a normalised situation. However, during our inspection the department escalated to a 'black' situation because of the numbers of patients waiting for beds in the hospital. We observed a trust wide response to escalation with medical staff from the acute medical receiving unit (AMRU) working in the department to care for patients. Staff from the department for research and education in emergency medicine, acute medicine and major trauma (DREEAM) worked clinically in the emergency department and allocated time for management activity was suspended. Senior managers attended internal risk meetings and the chief executive chaired a meeting with wider stakeholders as a way of taking action to address the risks to patients.
- It is usual for patients with mental health conditions to receive psychiatric assessment once they have been

assessed as medically fit. However, the adult emergency department had an agreement for fast track parallel assessment if patients presented with suicidal intent or were unlikely to be admitted to hospital.

- The department and the short stay observational ward used a yellow wrist band to indicate patients who were at risk of falling. They also used the wrist band to indicate any staff members who had been allocated the responsibility for monitoring patients at risk of falling. We saw staff take appropriate action to ensure patients were protected from the risk of falling.
- Ward safety thermometer data for the Lyn Jarrett Unit (LJU) showed patients had received 100% harm free care for the period between November 2015 and November 2016 with the exception of October 2016 where the figure was 90%.

Nursing staffing

- The trust had used appropriate tools and information to inform nurse staffing requirements. The trust told us they had begun a trust wide review of staffing establishment in July 2016 and this review would include the emergency department. At the time of our inspection the conclusions were not available.
- There were no nursing vacancies at senior levels in the department. However nurse staffing vacancies at band five (entry level) were high at the equivalent of 19.8% or 23.51 vacancies. At our last inspection managers told us that nursing staff retention had been a challenge, but they had introduced initiatives and had further plans to address this. At this inspection we found nursing staff retention for this group of nurses was still a challenge, although overall vacancy numbers had reduced. There were a number of reasons for this including crowding and pressure in the department, staff having to deal with challenging behaviours from some patients and also positive opportunities for development available within the trust.
- There were 3.5 vacancies for clinical support workers (CSWs) which was equivalent to 12.9%. There were no vacancies for emergency department assistants (EDAs).
- The department used an average of 8,500 hours of bank or agency nursing staff for the period November 2015 to November 2016. All agency staff in the adult emergency department and the Lyn Jarrett Unit received an induction and orientation.
- The electronic rota system used in the emergency department listed the skills of all nurses on duty. This would alert department leaders to any shortfall in skill mix.
- There were 19 advanced nurse practitioners (ANPs) working in the adult emergency department providing 24 hour care. Many of these were highly experienced and were able to assist with middle grade medical responsibilities. There were 11.5 emergency nurse practitioners (ENPs) employed to treat patients in the minor injuries area, with two additional vacant posts.
- Receptionist and clerical duties in the emergency department were completed by EDAs who also carried out patient observations and supported trained nurses in caring for patients.
- Care support workers were also employed in the emergency department to carry out observations and other clinical tasks, basic nursing care and the preparation of documentation for discharge.
- Nursing staffing levels and skill mix on the observation ward were appropriate. Handovers took place twice daily in the morning and then the evening. These were accountability handovers where each nurse took individual accountability for the patient and the accuracy of their records. Nursing handovers on LJU took place around the patient's bed and a handover sheet was completed each time.
- Nursing handovers, called 'roll call' took place in the emergency department at 7am and 7pm. All qualified and unqualified nursing staff attended. They were shown an electronic presentation of information including themes of complaints and any changes to practice. The outgoing nurse in charge gave information about the previous shift, patients in the department, cleaning and stock levels. A member of the department for research and education in emergency medicine, acute medicine and major trauma (DREEAM) team also attended to deliver short teaching sessions as appropriate. This staff member would also ensure agency staff had received an induction to the department which was recorded.
- Nursing staff were organised so that one senior nurse was on management duty each day. Two weeks prior to our inspection the department had introduced a flow coordinator which had released senior clinical staff to manage clinical issues instead of patient flow.

Medical staffing

Urgent and emergency services

- Consultants were present in the adult emergency department 24 hours a day. There were between one and six consultants present depending on the time of day and this was matched to demand as far as possible including out of hours and at weekends. To accommodate the numbers of patients waiting in the department for a hospital bed the team had added an additional consultant to the morning rota to ensure these patients could be reviewed leaving another consultant to take an overview of the emergency department patients awaiting review or treatment.
- All doctors on shift participated in a daily handover at 7:30am. During this handover they discussed learning from incidents and complaints. Following this doctors individually handed over the care of their patients to the incoming doctor. There were other doctor to doctor handovers during the day to accommodate staggered shift patterns.
- The department used an average of 2,500 hours of locum staffing between November 2015 and November 2016. The majority of these staff were familiar with the department.

Major incident awareness and training

- The emergency department had suitable major incident and business continuity plans. At our last inspection we asked the trust to consider holding major incident exercises in the emergency department to ensure staff were familiar with emergency planning and major incident procedures. Since our last inspection the trust had completed two desk top and one simulation exercise and staff were able to talk about these. We saw a copy of the programme for team days which had included major incident training. The trust provided data which indicated 94% of staff had received major incident awareness training.
- Security staff, provided by an external company, were present in the emergency department between 7am and 10pm each day. Outside of those times the department would receive a priority response if requested. Nursing staff told us the security team were highly effective and supportive. All staff were issued with personal alarms and they told us, when activated, support was promptly available. We saw evidence of this when an alarm was activated during our inspection. Closed circuit television was also installed in the department. However, a number of staff told us they did not report incidents of violence and aggression against themselves because of time constraints although they would always report patient related incidents. Some staff also told us there were not enough security staff to support them with high risk patients as there were only two security staff for the whole hospital. They told us the response from the police was slow on occasion and gave us a recent example where staff had telephoned several times for assistance before it arrived. This concern had been discussed at the emergency department clinical governance meeting in October 2016.
- Suitable arrangements were in place to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT).

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Relevant and current evidence based guidelines and standards were used to guide assessment of patients and the delivery of care and treatment.
- Patients' pain was assessed and managed appropriately and they were given drinks and where appropriate food.
- Information about outcomes for patients was routinely collected and monitored. The results were used to inform improvement actions.
- Staff were given the skills and knowledge to deliver effective care and treatment and there was an ethos of continual learning in the department.
- Staff, teams and services worked together to deliver effective care and treatment

However:

- Ongoing issues with the implementation of a new computer system meant staff did not always have the information they needed to deliver effective care.

Evidence-based care and treatment

- Relevant and current evidence based guidelines and standards were used to guide assessment of patients and the delivery of care and treatment. This included protocols for sepsis, fractured neck of femur and stroke

amongst others. There were 18 protocols in use for integrated assessment unit. Policies and protocols were based on National Institute for Health and Care Excellence (NICE) or Royal College of Emergency Medicine (RCEM) guidelines.

- The department participated in the RCEM audit programme. Following audits, action plans were developed by the local team and shared with local clinical governance and trust wide teams. Nursing staff in the department received feedback via the roll call and training reminders were delivered by DREEAM staff to support learning from audits.
- There was also an internal audit programme which included RCEM re-audits and locally agreed topics for audit. We saw the results of a recent audit of asthma which had showed poor documentation on the use of peak flow meters. An update was presented during the roll call and DREEAM educators offered one to one training to staff as a refresher on the use of the meters.
- There had been a recent re-audit of compliance in relation to the RCEM clinical standards for hip fractures and we saw the conclusions and recommendations for improved pain relief administration, prioritisation for diagnostic imaging and early referral to orthopaedic colleagues with a fast track admission pathway. There was a plan to re-audit these standards in 2017.
- The DREEAM team were in the process of setting up an Audit Quality Assurance (AQA) group to oversee audit. The emergency department had 12 multi-professional teams each assigned topics which they would champion and agree the audit plan.
- Staff were involved in the trust's shared governance system. Junior nurses were encouraged to have collective ownership to develop and improve practice in the department. Shared governance groups met twice a month to work on projects to improve patient care.

Pain relief

- Patient's pain was assessed and managed appropriately. Patients we spoke with told us they had received pain relief and records we reviewed showed consistent recording of pain scores and administration of pain relief.
- In the Care Quality Commission Accident and Emergency (A&E) survey for July 2016, the department's score for patients who said they pain had been controlled by staff had improved by one point from 6.7 to 7.6.
- We observed care support workers asking nurses for pain relief for patients where appropriate.
- The initial assessment unit was staffed by qualified nurses and an advanced nurse practitioner (ANP) who could prescribe pain relief. Patients were asked about their pain and given pain relief where appropriate; however the delays in initial streaming for patients arriving independently may have delayed early administration of pain relief.

Nutrition and hydration

- Water fountains and vending machines were available in the adult emergency department.
- There were arrangements in place for patients who had been in the department for any length of time to receive food and drinks where appropriate. Accompanying relatives and carers could access refreshments in the department or within the hospital.
- Most patients told us their dietary needs had been taken into account and they had received plenty to drink. We saw staff to getting drinks and sandwiches for patients. On occasions they were supported to do this by volunteers.
- Staff used green wrist bands to indicate patients who were nil by mouth.

Patient outcomes

- Information about outcomes for patients was routinely collected and monitored. This showed that intended outcomes for patients were being met.
- The department participated in the Royal College of Emergency Medicine (RCEM) audit programme. There was also a programme of local audit activity which included audits of sepsis management. The trust had a Commissioning for Quality and innovation (CQUIN) framework for sepsis. A CQUIN is a payment framework which enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. For the period June to November 2016, local audit results showed 62% of patients presenting with sepsis received the full sepsis bundle of treatment and 80% received antibiotics within one hour. The trust had set their own target for the period to end March 2017 at 70% and 90% respectively.
- We saw the results of a recent audit of asthma which had showed poor documentation on the use of peak flow meters. This information was used to take action

and make improvements. An update was presented during the roll call and DREEAM educators offered one to one training to staff as a refresher on the use of the meters.
- Between November 2015 and August 2016 the number of unplanned re-attendances to A&E within seven days remained constant at around 8%.
- The department was participating in the RCEM consultant review prior to discharge audits for 2016/17 and results were not available at the time of our inspection. Previous audit results were available but the department were concerned about the data quality for these and were awaiting the 2016/17 results for verification and challenge to their previous approach.

Competent staff

- Medical and nursing staff received appraisals. All staff we asked told us they had an up to date appraisal and their learning and development needs were identified during the process. Information supplied by the trust showed 94% of nurses and all doctors with one exception had received an appraisal within the previous 12 months. There were plans in place for those remaining staff.
- Newly qualified nursing staff wore orange lanyards which enabled other staff to offer support and made it easier for these staff to ask for it.
- Doctors' revalidation was supported.
- All staff told us they were encouraged and supported to develop their skills and practice. There was an ethos of continuous learning in the department.

Multidisciplinary working

- An urgent care centre operated by another provider was situated next to the emergency department providing services from 8am to midnight, with a GP present from 7pm onwards. Emergency nurse practitioners working in the streaming area of minor injuries and illness could refer patients to this service if their condition was appropriate for review by a GP. There was guidance available on admission avoidance through the use of the urgent care centre.
- A supported transfer of care (STOC) team supported patient discharge home or to community settings. They also saw and assessed patients on the short stay observational ward. Since our last inspection the service had been extended to cover weekdays from 7:30am to 8pm and at weekends from 8am to 6pm. Outside of these hours community health services did not accommodate patient discharges. The team also linked into the new acute frailty pathway pilot in partnership with the health care of the older persons team (HCOP). This pilot included the provision of 12 beds on ward F18 to which fail elderly patients requiring hospital admission could be admitted on an accelerated pathway with all admission processes taking place in the emergency department. A nurse from the health care of the older person (HCOP) team was based in the emergency department seven days a week (mornings only at weekends) where they would review patients and admit them directly to the older persons' assessment unit or facilitate discharge home. Emergency department staff would highlight patients meeting the criteria for review on the electronic system so they could be picked up.
- We saw good collaborative working between the emergency department and the acute medical receiving unit (AMRU). Medical staff from the AMRU attended the emergency department during busy times and offered support or identified patients who could be pulled from streaming for direct admission to the AMRU.
- The trust had standard operating procedures and protocols which outlined effective relationships and responsibilities across all divisions in supporting the care and flow of patients through the emergency department.
- The trust contracted three patient transport ambulances to make inter hospital transfers and on occasion to take patients home after they had been discharged from the department. We saw these staff helping out in the department when they had no patients to transfer.
- A specialist external service was available for patients with drug and alcohol dependencies if they chose to self-refer.
- Psychiatric assessment services were available to the emergency department, generally within 60 minutes of a request. This service was provided by the hospital's department of psychological medicine. The psychiatric liaison team met regularly with emergency department representatives to discuss improving services for patients with mental health conditions. Renewed governance arrangements were beginning in December 2016 so we were not able to see recent minutes of these meetings.

Urgent and emergency services

- A frequent attender / high impact service user nurse worked in the department. Their role was to support patients in this category to improve their health and wellbeing and reduce inappropriate hospital attendances and admissions.
- A cardiac specialist nurse was available to support the review of patients in the emergency department and the Lyn Jarrett Unit (LJU) between 7am and 7.30pm seven days a week.
- Police officers who attended the department with patients told us the staff worked well with them to enable them to do their job while they were in attendance.
- Imaging and radiology staff worked in the department collecting patients for diagnostic tests or conducting them there where appropriate and necessary.

Seven-day services

- There was a medicine divisional action plan in place to meet the NHS Services, Seven Days a Week, Priority Clinical Standard 2 which states all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital. Projects to improve weekend services included the Acute Frailty Unit, a 12 bedded frailty unit providing an increased presence of geriatricians seven days a week.

Access to information

- Staff had access to information about policy, pathways and support services on the trust's intranet. Patient care records were available to all staff electronically. When patients moved between services their information was transferred.
- A new electronic patient information system had been introduced to the department in the summer of 2016. Senior staff raised some concerns about the ability of the system to provide the information they needed to proactively manage the department. They reported that the previous system would automatically update the patient information system with the time they were seen and with numbers in the department. The new system had the capability to provide this information but additional coding had to be written which they believed was not seen as a priority. As a result it took staff more time to find the information and patients were more likely to complain about the lack of information.
- Staff were able to individualise the screen for the new system leading to different staff looking at or tracking information differently. There was no standard presentation format for patient information held on the electronic system. This meant when staff logged on they were not always seeing information presented in the same way which slowed down their ability to read and interpret it. On one occasion one staff member told us they were unable to understand the information because it was not set out the way they set out their screen.
- Information about ambulance arrivals and incoming ambulances was visible in the department, although was not consistently showing on the screen during our inspection. However, information about ambulance handover times was available on the department's electronic patient information system.
- Senior leaders told us the lack of access to data about patients, departmental status and ambulance handover times made it difficult for them to target improvement actions. They also indicated they were only able to be reactive rather than proactive about the challenges in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical and nursing staff understood their responsibilities under the Mental Capacity Act 2005. Staff sought consent from patients before treating them and patient consent was recorded in the records we reviewed. Where patients were unable to give consent, treatment was provided under best interest guidance and recorded appropriately. Credit card size reminders had been produced and issued to staff.
- Medical staff told us they encouraged early recognition of patients for whom a do not attempt cardio-pulmonary resuscitation order (DNACPR) was in place. We observed one doctor discussing a DNACPR with their patient.
- Nursing staff on the short stay observational ward were able to explain processes relating to deprivations of liberty.

Are urgent and emergency services caring?

Urgent and emergency services

Good

We rated caring as good because:

- Despite the overcrowding in the department staff cared for patients with compassion, patience and kindness.
- The majority of patients and their relatives told us they felt listened to and involved in their care and treatment.
- People were given support emotionally to cope with their treatment.

However:

- The overcrowding in the department made it difficult for staff to protect the privacy and dignity of patients.

Compassionate care

- Despite the overcrowding in the department staff cared for patients with compassion, patience and kindness. We observed several staff taking time to help patients with mobility or to respond to their needs.
- An emergency department assistant was allocated to support patients waiting in the central area of blue (majors). We saw these patients receiving blankets, drinks and food. We also carried out a short observational framework for inspection (SOFI) in this area of the department and saw only positive interactions between patients, their relatives and staff.
- Staff introduced themselves to patients before treating them. Where patients were receiving care and treatment in cubicles we observed staff closing curtains to protect people's privacy.
- We observed numerous examples of medical staff talking with patients with kindness and empathy.
- Volunteers were present in the department and we saw them taking time to talk with patients and reassure them. One volunteer remained in a waiting area with a patient who was alone, anxious and confused until they were taken in for treatment.
- We looked at patient complaints for the period November 2015 to November 2016 and there were four complaints about patient care.
- The friends and family test results for June to August 2016 showed 89% of patients would recommend the department to others.
- However, the overcrowding in the department made it difficult for staff to protect the privacy and dignity of patients. This was especially the case in the central area of majors where patients waited on hospital trolleys for cubicles to become available. There were patients of all ages, male and female with varying degrees of injury or illness and very little space between their trolleys. One patient told us they were very uncomfortable with being ill so close to other people and they were embarrassed about it.

Understanding and involvement of patients and those close to them

- The majority of patients and their relatives told us they felt listened to and involved in their care and treatment.
- We observed staff talking directly to a patient living with dementia in a sensitive and kind way as well as involving their relative in the conversation about their care and treatment.
- We observed one nurse caring for a patient who had a hearing impairment. They adapted their speech and tone and took time to a good explanation of the patient's plan for treatment.
- We observed one senior nurse discussing smoking cessation with one patient, encouraging them to stay in the department rather than leave to smoke whilst respecting their right to choose.
- However one relative told us they had been waiting a long time outside the resuscitation area and had to ask if they could be with their relative. They were particularly concerned that they had not been asked any questions as their relative was living with dementia and they were worried the nursing staff may not have accurate information.

Emotional support

- People were given support to cope emotionally with their care, treatment or condition. We observed numerous examples of staff speaking calmly to patients, reassuring them and not rushing them.
- We observed a patient who had a learning disability attend the department. The patient appeared to be in some distress. We observed the staff prioritised this patient taking account of their individual needs and the effect of the environment on them.
- During our inspection we talked with a trust chaplain who visited the department twice a week to offer emotional support to patients who wanted it. Chaplains were available at other times if requested.

Urgent and emergency services

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- The high levels of demand in the department had led to overcrowding and the nursing of patients in the centre of the majors area outside of cubicles.
- The service did not meet the Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival at A&E.
- There were insufficient seats for patients in the waiting area and no alternative seating for elderly patients or those with a disability. There was insufficient seating for relatives in the majors and resuscitation areas.
- Not all staff we spoke with were able to articulate any strategy in the department for supporting patients living with dementia.
- Patient leaflets were not readily available in different languages or accessible formats

However:

- Services were planned and delivered to meet the needs of local people and individuals.
- People's concerns and complaints were responded to and used to improve the quality of care.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform service planning and delivery. The trust was involved with local commissioners and other health care providers as part of the local urgent and emergency care vanguard. Vanguards are where groups of providers come together to change the way they work together to provide more joined up care for patients.
- A supported transfer of care (STOC) team supported patient discharge home or to community settings. They also saw and assessed patients on the short stay observational ward. Since our last inspection the service had been extended to cover weekdays from 7:30am to 8pm and at weekends from 8am to 6pm. Outside of these hours community health services did not accommodate patient discharges. The team also linked into the new acute frailty pathway pilot in partnership with the health care of the older persons team (HCOP). This pilot included the provision of 12 beds on ward F18 to which frail elderly patients requiring hospital admission could be admitted on an accelerated pathway with all admission processes taking place in the emergency department. A nurse from the health care of the older person (HCOP) team was based in the emergency department seven days a week (mornings only at weekends) where they would review patients and admit them directly to the older persons' assessment unit or facilitate discharge home. Emergency department staff would highlight patients meeting the criteria for review on the electronic system so they could be picked up.
- The facilities in the department were not always appropriate to support delivery of care to the local population. There were insufficient seats in the waiting area and no alternative seating for elderly patients or those with a disability. There were not enough cubicles in the majors treatment area for the number of patients. At times cubicles were doubled up in the resuscitation area to accommodate the numbers of patients. There were insufficient chairs in the reception area for patients waiting to see a streaming nurse at busy periods. We observed some ill or injured patients standing for up to an hour waiting to be seen. There were no chairs available for relatives and carers in the resuscitation area. Relatives and carers of patients waiting in the central area also had to stand for long periods of time as there were no chairs and no space to put seating close to patient's trolleys.

Meeting people's individual needs

- A telephone interpreter service was available for patients and staff knew how to access this. Some staff in the department spoke more than one language and would act as an interpreter if required in an emergency. A signing service was available for patients with hearing impairments.
- A frequent attender / high impact service user nurse worked in the department. Their role was to support patients in this category to improve their health and wellbeing and reduce inappropriate hospital attendances and admissions.

- A domestic violence nurse worked in the department offering advice and support to patients and also to staff dealing with this vulnerable group of patients.
- There were processes to refer patients at risk of self-harm to a mental health provider.
- Information about a support service was available for patients with drug and alcohol dependencies. We saw staff sharing this information with patients. They told us patients would self-refer.
- There were processes in place to support patients with a learning disability. Staff told us they could request the support of a learning disability lead nurse if required. They told us they reviewed 'About me' documentation which some patients carry so staff are aware how to meet their individual needs. We observed a patient who had a learning disability attend the department. The patient appeared to be in some distress. Staff prioritised this patient taking account of their individual needs and the effect of the environment on them. Patients with a learning disability arriving by ambulance were identified as a priority and moved to an area away from crowds to manage their anxiety if appropriate.
- Staff we spoke with were not able to articulate any strategy in the department for supporting patients living with dementia. One nurse when asked was able to locate an aid designed to reduce anxiety for a patient living with dementia but these had clearly not been accessed for a long time. There were high numbers of frail elderly patients in the department during our inspection.
- At our last inspection during 2015 we raised a concern about patient information leaflets and asked the trust to consider improving their availability as well as ensuring provision in languages other than English and in accessible formats. During this inspection we found patient information leaflets were not readily available in the emergency department. Staff told us they could print them from the computer system as required and were able to provide several examples when asked. However, leaflets were not readily available in different languages or accessible formats.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at A&E. Between November 2015 and November 2016 the adult emergency department consistently performed below the standard and below the England average. For the month of October 2016 performance was 79.3%.
- In September 2016 the percentage of patients spending less than four hours in the department was 81.2% compared with an England average of 89%. Twelve months previously 92.5% of patients had spent less than four hours in the department. For the same period 79.1% of patients spent less than four hours in the majors area of the department compared to an England average of 86% and a trust figure of 91.8%, 12 months prior to our inspection.
- An average of 12% of patients waited in the department for longer than six hours during the period November 2015 to October 2016 with the lowest percentage of 5.5% in September 2016 and the highest of 16% in June 2016.
- The percentage of patients waiting 4-12 hours from decision to admit to admission had increased from 2% in September 2015 to 16% in September 2016 against a national average waiting time for this category of 10%. In October 2016 this number had fallen to 5.5%. However no patients waited more than 12 hours from decision to admit to admission during the same period against a national average of 1%.
- Between September 2015 and August 2016, 5% of patients left without being seen. This was an increase of 2.3% on the previous 12 months.
- The high levels of demand in the department had led to the nursing of patients in the centre of the majors area outside of cubicles becoming normalised for staff. At times there were up to 26 patients in the department awaiting a bed in the hospital. These patients, the equivalent of a ward cohort, were being cared for by emergency department staff in addition to emergency patients awaiting assessment and treatment. At times they remained in the department overnight because of the lack of beds in the main hospital.
- There was sometimes confusion over roles as a number of people were responsible for bed management in the hospital and emergency department staff were informed of bed availability from various sources which could make it difficult for them to keep track of available beds. However a new bed management module was due to go live on the computer system shortly after our inspection.

Urgent and emergency services

- Site managers and senior hospital leaders were highly visible in the department working on ensuring available beds were allocated to patients who were waiting for admission. The four hour standard for emergency departments was seen by most divisions as a hospital wide target.
- However, in the majority of cases staff prioritised care and treatment for people with the most urgent needs and worked hard to maintain patient safety despite excessive demand and poor patient flow. Nursing staff were allocated to ensure the safe care and treatment of patients waiting on trolleys in the central area of majors. When patients were required to stay in the department overnight because of lack of beds, they were transferred onto hospital beds. During our inspection we say the ambulatory care unit was closed overnight and used to care for patients who would usually be receiving inpatient care. All appropriate observations and assessments had been completed for these patients during this time. Ambulatory care patients were treated during this closure in the minors area of the department.
- There was an ambulatory care unit in the department where patients could be seen without hospital admission. There were clearly defined protocols and pathways to determine which patients could be seen in this area.
- Televisions in the waiting areas displayed information about waiting times and periodically an apology for the delay.
- During busy period medical staff from the acute medical receiving unit (AMRU) visited the emergency department and would review patients and identify suitable patients to pull from the streaming process for direct admission.
- Flow coordinators had recently been appointed in the department for a six month trial period. They were present 24 hours each day and their role was to coordinate and manage the flow of patients, to ensure investigations and treatments were completed in a timely manner and to coordinate patient transfers.
- A trust emergency pathway task force chaired by a deputy director was meeting every two weeks to look at improving patient flow through the hospital and a focus on divisions pulling patients through the hospital rather than the emergency department having to push them through.

Learning from complaints and concerns

- Systems and processes were in place to enable patients and relatives to make a complaint. Information about how to complain was available in the department. Staff understood their responsibilities to support people to complain. During our inspection we saw a senior doctor support a patient's relative to make a complaint.
- Learning from complaints was shared with all staff at every roll call in the emergency department and complaints were discussed at emergency department clinical governance meetings each month. The two top themes for complaints during the period November 2015 to November 2016 were communication failures and diagnosis, scans and tests. Two complaints had been referred to the Parliamentary and Health Service Ombudsman during the previous 12 months.
- Complaints were handled effectively and complainants received information and updates. There was openness and transparency about how complaints were dealt with and we saw letters which had been written to patients and relatives.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- Local leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.
- There was an effective governance framework with a collective ownership for quality.
- Performance and risks were generally understood and managed appropriately.
- The head of service encouraged openness and transparency and all leaders promoted high quality care. There was a supportive culture focussed on continuous learning.
- The public and staff were encouraged to be involved with service delivery models and improvement and there was a robust focus on continuous improvement and sustainability.
- There was strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.

However:

- Whilst there was inspirational leadership on the ground in the department the trust board had yet been unable to find a solution to the severe overcrowding.
- There was a risk that high demand, unrelenting pressure and staff perception that they were providing a poor service would lead to a demoralised culture and a lack of service sustainability.
- At the time of our inspection the senior team had not recognised some of the risks associated with the streaming process.

Leadership of service

- Local departmental leadership included a head of service and an interim general manager.
- The head of service was highly visible in the department and well respected by all staff. The leadership of the department was described as inspirational. They were passionate about providing a high quality, safe service and all staff told us they were approachable.
- Trust leaders were often seen in the department and the wider hospital community attended to support escalation. The site manager was highly visible in the department during busy periods. Senior nurses told us there was corporate support available to them out of hours. They told us they felt very supported by senior leaders in the trust. The on call site matron and the senior manager who had "Silver Command," would regularly attend the department. They also told us the senior leaders would offer practical help in the department and help transfer patients to the wards.
- All leaders were focussed on the delivery of high quality patient care. Following escalation by the head of service an extraordinary meeting had been held to address the concerns of the senior clinical leaders. These related to crowding in the department, patient safety and unrelenting demand. Leaders in the emergency department spoke very highly of the support and engagement from the chief operating officer and the chief executive in addressing their concerns.
- Although senior staff we spoke with told us the trust board were engaged with their work in the emergency department, the trust board had yet to find a clear solution to address the severe overcrowding in the department.
- At the time of our inspection the senior team had not recognised some risks associated with the streaming process

Governance, risk management and quality measurement

- The local leadership had escalated concerns of overcrowding in the department to the senior leadership team as a risk and impacting on patient experience, however the trust board had yet to find a solution to the overcrowding.
- There was an effective governance framework in place. There were monthly emergency department clinical governance meetings. Staff were involved in the trust's shared governance system. Junior nurses were encouraged to have collective ownership to develop and improve practice in the department.
- Shared governance groups met twice a month to work on projects to improve patient care. We reviewed clinical governance minutes from three meetings and observed that staff had agreed to ensure locum doctors worked in the major area to enable them to seek advice from colleagues more easily.
- There was a departmental risk register which was regularly reviewed. Senior leaders in the department were aware of and spoke confidently about their risks and how they were addressing them. Any risks we raised with departmental leaders during and after our inspection were immediately addressed and mitigated.
- There was an annual programme of external and internal audits. Results were collated and shared and improvement actions taken. We saw examples of audit results for sepsis, fracture neck of femur and asthma. There were documented recommendations and action plans and regular re-audit took place where appropriate to measure the quality of care and evidence improvement.

Vision and strategy for this service

- The department had an annual plan which included service specific objectives as well as how they would contribute to the trust's objectives. This was due for renewal in January 2017.
- Staff were aware of the trust's vision and values.

Culture within the service

- All staff were focussed on the delivery of high quality, safe care for patients. All staff appeared calm, kind, professional and pleasant despite very difficult circumstances with crowding in the department a

normalised situation. However, the pressure placed on all staff from the level of demand in the department was recognised by leaders and the staff themselves as unsustainable.

- Staff at all levels told us of their concerns about the impact on patients and on staff of the crowding in the department. Whilst proud of the work they did and their teams, staff were upset that they were unable to provide the care they wanted to because of the number of patients. One senior doctor told us they felt they were no longer able to do their best for patients and had to focus on maintaining safety which caused a great deal of stress for them. A consultant told us there was relentless pressure and stress. One consultant told us the team were all good people trying hard and coming up with new ideas for improvement despite the pressures. All staff, including the head of service had worked to address these issues and escalated them where solutions required the wider involvement of the trust and other partners.
- Consultants told us the chief operating officer had a good understanding of their department, attending their departmental meeting annually and provided good support to them.
- We observed staff being respectful and supportive of one another and on one occasion we observed a consultant who was finishing their shift thanking the team for working so hard.
- Many staff told us there was not a blame culture in the department, rather a learning culture and senior leaders gave us examples of staff suggesting improvement ideas which had been acted upon.

Public engagement

- The trust had a patient public involvement group and members of staff from the emergency department attended the group and also led on public engagement within the department. The patient public involvement group had supported the department with peer reviews, benchmarking and local commissioner led projects. Some changes had been made to the minors area based on the feedback from service users
- Patients had been surveyed in 2014 and again in September 2016. We saw the action plan from the earlier review but results from the more recent survey were yet to be received from the external company managing the survey.
- The head of service told us about an initiative they had led around experience based design where how the patient felt was considered against how the staff member thought they were feeling. We reviewed information provided where the team had visited each area of the department, asked staff how they thought patients were feeling and patients how they were actually feeling so that staff could understand their perspectives and reduce assumptions.

Staff engagement

- Leaders prioritised the participation and involvement of staff in improvement work, for example staff could take lead roles and had the opportunity to contribute to audits. The department held team days where staff could practice their skills through scenario and simulation work. Away days were held for some nursing staff groups.
- Staff told us they enjoyed working in the department and felt listened to. Nursing staff enjoyed the variety of work and the fact that they were rotated around the departmental areas.
- The quarterly staff survey results for July to September 2016 showed 82% of staff who responded would recommend the department to friends and family if they needed care or treatment. The percentage who would recommend the department as a place to work was 63%.
- During the nursing roll call there was a section entitled ‘awesome feedback’ where positive patient feedback was shared with the team.
- The inspection team was impressed by the resilience and commitment of the workforce in the face of unrelenting demand, high levels of scrutiny and a highly pressurised working environment.
- The DREEAM team had worked with leaders to produce a team working model and presentation for staff. As the department had grown to approximately 500 staff, leaders recognised the decline of historical mentor groups and the staff support they had provided. The new model was based in inter-professional teams and had the aim of overcoming some of the challenges of operating in such a large workforce, recognising the importance of team working, the effect on staff job satisfaction and the resulting positive impact on patient care.

Innovation, improvement and sustainability

- There was an ethos of continuous learning in the adult emergency department and the Lyn Jarrett Unit. Despite the overcrowding and pressures in the department the head of service was proud that no mandatory training sessions or teaching sessions had been cancelled over the previous 12 months.
- One consultant was the nominated improvement lead for the department and was involved in a number of projects designed to improve services such as the ambulance handover project and the flow coordinator project.
- The matron was the owner of a project to improve accountability handovers and to increase compliance with full completion of data on patients' electronic records.
- One Advanced Nurse Practitioner (ANP) in the department had achieved clinical prescriber status from July 2016. This was the first example in England of an ANP being qualified to prescribe clinical trial drugs.
- The department had secured funding to test an admission prediction tool which could help to improve patient experience, reduce unnecessary investigations and admissions and the patient's length of stay in the emergency department. The project was running from October 2016 to October 2017.
- The department were changing to a patient streaming service led by primary care nurses. Training had been delivered to these nurses by the DREEAM team and the objective was to ensure patients were seen in the right place first time. The department had recognised that many patients attended accident and emergency departments because of the branding and the availability of 24 hour services. The presence of primary care practitioners at the front door of the department enabled them to ensure patients were directed to the appropriate service for their needs.
- Medical staff were focused on continually improving the quality of care. A number were involved in research and academic projects, some of which had been nationally recognised.
- Several nursing and medical staff raised concerns with us about multiple changes to clinical information technology systems which they reported had slowed care down and added to the pressure the department was already facing because of unrelenting high demand. In the summer of 2016 a new electronic observation and handover system had been introduced. This coincided with the launch of a new patient management and information technology system.
- The head of service told us they had recognised the pressure on the team and had written to the executive leadership asking for help. The executive team had responded and had run some sessions with consultants in the department to understand their concerns. An extraordinary meeting was chaired by the chief operating officer and many consultants told us they were very impressed with this support. The trust leadership had in turn engaged external stakeholders in an attempt to develop solutions to overcrowding in the department. Senior managers told us there had been some progress initially with an increase in community beds available but that that more support was required from the wider health community to ensure the sustainability of services.

Outstanding practice and areas for improvement

Outstanding practice

- Nursing handovers, called 'roll call' took place in the emergency department at 7am and 7pm. All qualified and unqualified nursing staff attended. They were shown an electronic presentation of information including themes of complaints and any changes to practice. The outgoing nurse in charge gave information about the previous shift, patients in the department, cleaning and stock levels. A member of the department for research and education in emergency medicine, acute medicine and major trauma (DREEAM) team also attended to deliver short teaching sessions as appropriate. This staff member would also ensure agency staff had received an induction to the department which was recorded.

Areas for improvement

Action the hospital SHOULD take to improve

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- The trust should review what measures could be taken to reduce severe overcrowding in the department.
- The trust should ensure patients in non-visible cubicles in the majors area have call buttons or equivalent to summon help when required.
- The trust should keep under review the measures introduced to ensure the safety of patients waiting for streaming in the minors area or waiting for review and treatment in the central area of majors. This to ensure the risk continues to be responded to and mitigated.
- The trust should ensure there is a robust system for the reporting and logging of faulty or damaged equipment and that this system is fully understood by all staff.
- The trust should ensure staff and patients in the emergency department have a surface on which to locate notes, clinical equipment and refreshments, which is not an infection risk.
- The trust should ensure there is sufficient, appropriate seating in the reception area for patients awaiting streaming.
- The trust should ensure leaders in the emergency department have access to real time information and data which will enable them to target improvement actions and proactively, rather than reactively, manage the department.
- The trust should ensure all staff understand the department's approach to supporting patients living with dementia and are able to deliver care which is appropriate for these patients.
- The trust should ensure patient information leaflets are readily available in the emergency department in appropriate formats and languages to meet the need of the local population.
- The trust should consider how patient information can be displayed on the computer system in a consistent format to speed up review and ensure consistency.