

Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Inspection report






Colney Lane
Colney
Norwich
NR4 7UY
Tel: 01603286286
www.nnuh.nhs.uk

Date of inspection visit: 01 June 2021
Date of publication: 30/07/2021

Ratings

Overall rating for this service

Requires Improvement 

Are services safe?	Requires Improvement 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive to people's needs?	Requires Improvement 
Are services well-led?	Requires Improvement 

Our findings

Overall summary of services at Norfolk and Norwich University Hospital

Requires Improvement ● → ←

We carried out this unannounced focused inspection on the 1 June 2021 because at our last inspection on 8 December 2020, we identified a breach of the Health and Social Care Act (2008) Regulation 12, Safe Care and Treatment. Concerns were based on long waiting times for assessment, the uses or infection, prevention and control measures and staffing levels. We issued the provider with a warning notice served under Section 29A of the Health and Social Care Act 2008. Between January 2021 and 1 June 2021, the trust saw 22,870 children and 149,732 adults within its urgent and emergency care service.

At our inspection on 1 June 2021, we focused on the Care Quality Commission (CQC) domains of safe, responsive and well led. We rated the service as requires improvement for responsive and good for safe and well led. The overall rating has improved for urgent and emergency services from requires improvement to good.

We found:

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

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

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The 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 staffing levels and skill mix and gave locum staff a full induction.

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.

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

Our findings

Staff felt respected, supported and valued. 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.

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

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

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

However:

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

Access to support for patients who required support with their mental health remained a challenge within the trust.

Urgent and emergency services

Good ● ↑

Our overall rating for this service improved. We rated it as good.

Is the service safe?

Good ● ↑

Our rating of safe improved. We rated it as good.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. This was an improvement from our previous inspection.

The service generally performed well for cleanliness. Data supplied by the trust following our inspection showed that compliance ranged between 97% and 100%. The service took actions where any service fell below the 100% standard.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Clear signage reminded staff, patients and any relatives of restricted access to high risk areas. All ambulatory patients were met at the ED reception by a nurse navigator, who asked patients if they had any symptoms in relation to COVID-19, or any other infectious disease. They were then directed to the appropriate area.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last 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 ensured they were wearing the appropriate PPE for the environment they were entering and reassured patients whilst donning this.

The design of the environment followed national guidance. The trust had repurposed ED areas due to the impact of the COVID-19 pandemic and the need to maintain social distancing and the separation of patients with COVID-19 or symptoms of the infection. There had been repurposing of space to enhance the departments responsiveness to patient needs. However, the ED team had ensured during the COVID-19 pandemic that rooms used for patients who required mental health support had remained open and not changed to alternative use. This was an improvement on our last inspection.

Urgent and emergency services

Staff carried out daily safety checks of specialist equipment. This was an improvement from our previous inspection. However, identified that staff had not completed the ambulatory resus trolley checks on two occasions in May 2021, but all the equipment within the trolley was fit for purpose and we raised this with staff at the time of our inspection who escalated this to the nurse in charge.

The service had suitable facilities to meet the needs of patients' families. The leadership team had taken steps following our last inspection to manage the environment effectively including ensuring social distancing was in place, segregation of seating, clear signage and guidance for patients and relatives on waiting times.

The service had enough suitable equipment to help them to safely care for patients. We checked an additional ten items of equipment, for example monitors, probes and ultrasound equipment and found these all to be within service date, visibly clean and ready for use.

Staff disposed of clinical waste safely. Sharps bins we reviewed were labelled, closed and visibly clean.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. 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 trust used the national early warning score system (NEWS2) for adults and the children's early warning score (CEWS) for children. An early warning score is a guide used by staff to quickly determine the degree of illness of a patient. Staff used a "Bay watch" system to give oversight of any patients who were likely to deteriorate or needed additional support. There were hospital wide outreach services to support deteriorating patients.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. This was an improvement on our last inspection. Data supplied by the trust following our inspection showed that the trust did not meet the 15-minute triage target consistently. The ED leadership team were focused on improving performance as part of their "Safer, Better, faster" project and consistently reviewed data to try and drive improvements. The ambulance crews would telephone the ED teams in advance if they were caring for patients who needed specialised support.

Staff knew about and dealt with any specific risk issues; these included the management of sepsis, neutropenic sepsis, stroke, falls and frailty. The trust monitored compliance with training around specific risk issues such as resuscitation, sepsis and NEWS/CEWS and had a plan to address where compliance was below the desired level.

The service had 24-hour access to mental health liaison and specialist mental health support who were located within the adult ED. Staff within the ChED could access mental health support for children by calling a dedicated mental health line to local mental health agencies for children, including an out of hours services. Staff at all levels with told us that mental health support for patients remained one of its biggest challenges but that they were working with other agencies and organisations to try and improve services.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had a standard operating procedure for the management of mental health pathways within the ED. Risk assessments for the environment were in place and regularly reviewed by the trust's health and safety team.

Urgent and emergency services

Staff shared key information to keep patients safe when handing over their care to others. The team monitored performance against the internal standards for patients being seen within one-hour after referral to a specialism, for example the surgery or medical teams. The compliance with this target fluctuated with the capacity of the hospital however, this was monitored and reviewed.

Shift changes and handovers included all necessary key information to keep patients safe. We observed two safety huddles and observed staff pass on key information in relation to patients, performance and identifying patients who may need additional support.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

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. Where there were deficits to the planned numbers the nurse in charge took appropriate action, for example delegating staff from other areas or requesting additional support from the bank or agency to ensure all areas were safely staffed.

The department manager could adjust staffing levels daily according to the needs of patients. Managers used a safer staffing bundle to guide this process. The paediatric nurse staffing met the royal college of paediatric and child health's (RCPCH) national guidance as per recommendation 10: EDs treating children must be staffed by two registered children's nurses. During our inspection we found the safety nurse role was actively engaged in managing patient safety with an oversight on patient risk. This role was supernumerary, and one was allocated to each shift in advance on the staffing rota. The safety nurse shifts were planned, and staff told us that managers ensured this role remained focused on safety and risk. At times this role could be used to support other areas of the department dependent on demand.

Data supplied by the trust post inspection showed that as of April 2021, the ED had a 17% combined vacancy rate between adult and paediatric nursing. Sickness rates amongst nursing staff had reduced from 9.4% in January 2021 to 6.5% in April 21 and the turnover rate remained low at 0.4%. The use of bank and agency nurses had reduced during the same period from 41 shifts in January to 29 in April 2021. Senior staff we spoke with during our inspection told us that they had had recruited to all vacancies for band seven and six nurses and had recruitment plans to fill the remaining band five posts by the summer.

Nursing staff we spoke with told us they had access to a range of training and development opportunities and data provided by the trust showed 92% appraisal compliance for nurses as of May 2021.

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 staffing levels and skill mix and gave locum staff a full induction.

Urgent and emergency services

The service had enough medical staff to keep patients safe. The service had successfully recruited with all medical vacancies within the ED. This was an improvement on our previous inspection. The service met the Royal College of Paediatric and Child Health's (RCPCH) national guidance to provide a PEM consultant as per recommendation 9: *EDs treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics.*

The service had reducing vacancy rates for medical staff. One consultant had a focus on recruitment and retention which had enhanced the rates in both areas.

The service had low turnover rates for medical staff. This was currently at 0% and had dropped from 7% in February 2021.

Sickness rates for medical staff were low and reducing. Sickness rate amongst the adult and paediatric medical team had reduced from 7.1% in January 2021 to 2.7% in April 2021.

The service had reducing rates of bank and locum staff. The trust used 50 bank shifts in January 2021, this had reduced to 19 in April 2021, with plans to reduce this further following the successful recruitment of additional medical staff.

Managers could access locums when they needed additional medical staff. A significant portion of the locums did at least three shifts in ED each week and were established and used to working in the ED. All doctors who took up locum shifts had an inbuilt induction where they learnt how to use the trusts electronic systems within the ED.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Lead staff reviewed ChED's medical staffing twice weekly as part of their weekly staffing review to ensure appropriate staffing was in place. They were seeking to create an East of England paediatric emergency medicine training scheme in the future. Staff were encouraging medics to take up lead roles for ultrasound, mental health, teaching and trauma. The department had an established program of teaching and if a session was cancelled staff completed incident reports to highlight the cancellation.

The service always had a consultant on call during evenings and weekends. Medical staffing met with Royal College of Emergency Medicine (RCEM) recommendations of 16 hours of consultant presence per day.

Medical staff we spoke with told us they had access to a range of training and development opportunities and data provided by the trust showed 96% appraisal compliance for medical staff as of May 2021.

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 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.

Urgent and emergency services

Managers planned and organised services, so they met the needs of the local population. At the time of our inspection services had been reconfigured in response to pandemic and national guidelines and worked with system partners to facilitate care. The emergency department strategy 2020-2025 was developed with staff within the emergency department and external stakeholders.

The service relieved pressure on other departments when they could treat patients in a day. The same day emergency care (SDEC) pathways were in their early stages for ambulatory walk-in patients. The SDEC aims were to reduce the number of patients who would otherwise be admitted to the hospital or wait for extended periods in the ED. This was part of the trusts response to patient flow and aiming to reduce patient waiting times.

Access and flow

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

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. There were processes in place to ensure patients were monitored throughout their wait in the service.

Whilst the trust was not meeting the national target for the percentage of ambulances unloading within 15 minutes of arrival, we noted an improvement between February (52.6%) and May 2021 (56.8%). This showed an improvement from our last inspection.

The impact of the covid pandemic and high levels of demand within the department was seen in compliance with the target for patients waited 4 to 12 hours from decision to admit. This fluctuated between our inspections and was currently 33% in May 2021. However, this was an improvement on our last inspection in December 2020.

Managers monitored waiting times and made sure patients could access emergency services and received treatment. However, some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge. We reviewed five patients who had been waiting beyond the four-hour target, in one case over 13 hours. The trust ensured that all patients who were waiting had actions were in place including prompt review and nursing checks. Unfortunately factors such as waiting for transport, waiting for additional clinical review, or mental health placement were key factors affecting the patients waiting times.

In January 2021, the median time from arrival to initial assessment (emergency ambulance cases only) was 28 minutes. Royal College of Emergency Medicine (RCEM) triage standard says that triage should be a face-to-face encounter that should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact. The trust project “Safer, faster, better – emergency care improvement programme” was focused on improving performance and the data showed an improvement from our inspection in December 2020.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Data supplied by the trust following our inspection showed that the ED failed to achieve this target for the four months prior to our inspection. Compliance improved during February and March but dipped again in May 2021 to 53.7%. The ED team had actions in place to try and improve performance in this area including the trust project “Safer, faster, better – emergency care improvement programme” focused on improving performance.

Urgent and emergency services

In January 2021, the percentage of ambulance handovers that were longer than 60 minutes from arrival was 7.1%. This improved between February and 2.4% May 2021 (2.4%). This is an improvement on performance from the same period in 2020. Staff followed Royal College of Emergency Medicine (RCEM) standards and were not cohorting patients in corridors. Patients were however, being held on ambulances due to capacity issues within the wider hospital. The rapid assessment and treatment service (RAT's) area enabled staff to work with the local NHS ambulance trust to identify any patients likely to deteriorate whilst waiting to be seen and consultant cover enabled a clinician to review patients in a timely fashion.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

At our last inspection December 2020, we found leaders were not always aware of risks and issues. At our most recent inspection we found this had improved. Leaders were aware of the risks in relation to the emergency department (ED), there were clear lines of accountability and plans in place to monitor and improve performance and manage risk.

Urgent and emergency care services were led by a nurse director, associate medical director, and operations director. Operationally the service was led by a senior matron, service director and operations manager. We spoke with the nurse director who explained they had increased the leadership team operationally since our last inspection in December 2020 and appointed a nurse consultant to the team to increase leadership capacity and drive improvement.

Day-to-day oversight of the department was managed by the senior matron, service director and operations manager. Nursing and medical leads we spoke with had the relevant competencies, skills and experience for their roles and had led the emergency department throughout the COVID-19 pandemic providing hands-on support for the workforce.

Leaders had maintained a focus on recruitment and made changes within the workforce to ensure stability and sustainability. Staffing levels were now manageable and there were plans in place for additional recruitment to strengthen the staff team further.

We observed that leaders were visible and approachable in the service for patients and staff and staff clearly understood the leadership of the ED and who to contact to escalate concerns within the service.

Leaders implemented escalation plans and processes, ensuring that staff understood and followed them. We observed site operation staff working closely with the ED leadership team to manage any concerns regarding patient flow, identify additional resources and encourage patient movement to increase capacity.

Vision and strategy

Urgent and emergency services

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

ED leaders had an Emergency Department Strategy 2020-2025 and a vision to be “An outstanding emergency department that supports our staff to provide the best possible care to our patients.” All staff we spoke with were aware of the ED strategy and vision, and involved in the local developments, for example the recent changes in the environment, the new building works and design of the emergency care pathway.

We observed staff safety huddles that focused on the key priorities within the strategy, for example ED performance, patient waiting times, safety and managing risk. Staff we spoke with had opportunities to develop their skills and competencies, the ED leadership team were focused on the future needs of the ED whilst balancing the day-to-day demands of the department, which had seen a surge in ambulatory patients due to relaxation of some of the national public COVID guidance.

Culture

Staff felt respected, supported and valued. 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.

The COVID-19 pandemic had been extremely challenging for the ED and wider hospital teams. Staff spoke about their experiences during the pandemic and the impact this had taken on their wellbeing and morale. During our inspection we observed a culture of positive patient and staff interaction. Staff were focused on meeting patient needs and ensuring their safety. Performance data was routinely discussed, and staff openly challenged each other regarding waiting times and treatment options.

Consultants we spoke with described a positive culture of working together and there was a focus on promoting the internal professional standards (IPS) to provide more support in the department from other specialties.

There was a positive working relationship and team approach between the ED staff team and the local NHS ambulance trust. ED and ambulance staff valued each other and identified any issues likely to impact on the ED, for example pre-alerting for complex arrivals. We routinely observed positive interactions between ambulance staff and the ED team and the hospital ambulance liaison officer (HALO) focused on ensuring ambulance staff worked alongside the ED team to achieve performance targets and promote safe care.

The safety nurse role promoted a culture of challenge and safety when routinely reviewing patients and ensuring their care plan was being monitored and patients at risk of deterioration were managed appropriately.

Data supplied by the trust following our inspection showed that in the 2020 NHS staff survey for emergency and urgent care 88% of staff always knew their work responsibilities and 69% of staff said they felt the team had shared objectives. Seventy percent of staff said they received respect from their colleagues and 85% said they got support from work colleagues.

Leaders operated effective governance processes.

Urgent and emergency services

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The ED had robust governance processes in place, holding governance meetings monthly, urgent and emergency care risk management meetings monthly and a weekly ED action evidence meeting.

A range of additional ED meetings, for example the senior nurses meeting, band five, six and seven nurses meetings and the ED staff meetings provided staff with opportunities to feedback on concerns, complaints, incidents, friends and family feedback as well as sharing good practice to the wider governance structure teams.

These meetings fed into the monthly emergency and urgent care governance meeting, and the monthly emergency and urgent care board.

We reviewed the clinical governance meeting minutes from 25 March 2021, 22 April 2021 and 27 May 2021. Minutes demonstrated leaders discussed key risks and performance issues likely to affect patient safety, treatment times and well-being. The governance process was underpinned by local and national audits, the ED participated in a wide range of audits focused on improving quality and performance.

The ED had a dedicated quality improvement plan to deliver against any concerns raised in previous Care Quality Commission (CQC) inspections. The plan was RAG rated and had key lines of accountability for making improvements. Areas still needing development were ongoing staff recruitment, staff training and improving patient waiting times.

As part of the ED care governance structure, the ED team have developed a Wellbeing Group to oversee and provide a framework to protect and improve the health, safety and wellbeing of all ED staff.

We reviewed mortality and morbidity meeting minutes from 28 January 2021, 25 March 2021 and 27 May 2021. Minutes demonstrated that staff reviewed patient deaths to identify any concerns in relation to care or treatment, and discuss the lessons learned from incidents. We noted discussion on treatment pathways, the use of policy and escalation and reflective practice to determine if deaths could have been avoided or if changes were required to improve safety and manage risks.

Managing risks, 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The ED leadership team had developed a project “Safer, faster, better – emergency care improvement programme”. An example of the project work streams included initiatives within the rapid assessment and treatment service (RATs) to improve performance and patient safety. The project focused on standardising processes within RATs whilst keeping the processes safe and effective. ED leaders were aiming improve the ED’s ability to meet the demands placed upon it from patients who arrived via ambulance. The ED were developing metrics to demonstrate prompt interventions and treatments had taken place and identify any gaps in performance.

ED leaders maintained a “Safer, faster, better action and risk log”. This enabled them to identify additional risks within the service, assign these to individuals to ensure accountability for improvements in performance and RAG rate additional risks to show improvements had been made or where additional improvements were required.

Urgent and emergency services

The ED risk register had four main risks including: -

- A lack of physical capacity to perform initial nursing assessment on patients who do not arrive by ambulance in a timely fashion.
- Lack of adequate capacity of ED waiting rooms (mains and minors Norwich).
- The impact of delayed decision to admit within the ED.
- Delays in assessment/Treatment due to medical staffing shortage.

Leaders were aware of the risks within the ED and we observed mitigation in place to manage these, the risk register was reviewed on a monthly basis as part of the governance processes, however risks could be escalated and reviewed sooner by leaders if necessary. For example, the changes to the ambulatory assessment area to clearly identify patients at risk of deterioration, building works to create a new reception, assessment and navigation area to manage patient flow and demand. The ED had made significant improvements in medical and nursing staffing through its recruitment processes and were on target to have a full medical team by August 2021, to improve delays in patient treatment and assessment.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The ED used electronic patient record systems to maintain security of patient details and use live data to manage treatment plans and escalate patients who were at risk of deterioration.

Performance data was shared at all safety huddles and during staff handovers. Staff had access to live performance data via secure electronic systems and electronic displays in order to review and improve performance, for example ambulance arrivals, priority patients and waiting times.

Audit data was available to staff via the trusts intranet and we observed performance and risk data displayed on notice boards in key areas throughout the ED.

Learning, continuous improvement and innovation

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

The ED team developed the “Foundation Programme” following the introduction of the Emergency Care Assistant and Royal College of Nursing National Curriculum and Competency Framework – Emergency Nursing Level 1 to the Department. The ED team recognised that there were many staff competencies to achieve. The team created an 18 month programme, known as the “Foundation Programme” where newly qualified or new to speciality nursing team are separated into five groups, each group participated in a study around every two months to support them on ‘The Road to Becoming an Emergency Nurse’.

Urgent and emergency services

The ED education team ensured that bank and agency nursing staff were orientated and supported in the department including a supernumerary process, induction packs and checklists to complete. The education team worked with the nurse bank and were notified when there was a new agency nurse in the department to ensure timely orientation.

The education and governance team developed a department initiative called 'Governance - where Governance meets Education.' The teams met monthly to discuss a monthly focus, for example, falls February, medicines March and the Mental Capacity Act and Mental Health May.

The education team created a healthcare assistant competency pack including a programme that supported their professional development.

The ED action evidence group was created to ensure that serious Incident actions were being met and learning from incidents was shared throughout the ED.

At the time of our inspection the trust was engaged in a documentation quality improvement project to support more engaging ways of sharing the changes on the trusts electronic record system.

Areas for improvement

MUSTS

Urgent & Emergency Care

The trust must ensure they continue to do all that is reasonably practical to improve key national and trust performance targets such as the four-hour standard, triage within 15 minutes of patient's arrival, internal professional standards and time taken from decision to admit, ensuring risks to patients are effectively mitigated. (Regulation 12).

SHOULD

Urgent & Emergency Care

The trust should ensure that European Paediatric Life Support should be completed by appropriate staff by January 2022.

The trust should ensure that staff complete checks on emergency medical equipment in line with trust policy.

Our inspection team

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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