Wirral University Teaching Hospital NHS Foundation Trust

Arrowe Park Hospital

Quality Report

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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.

Ratings

Overall rating for this hospital

Urgent and emergency services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Arrowe Park Hospital is an acute hospital that is part of a number of services operated by Wirral University Teaching Hospital NHS Trust. The hospital serves a local population of around 330,000. From November 2017 to October 2018 the emergency department saw 96,668 attendances, of which 20,884 were children. Total attendances had decreased by 3% from the previous year. During this period 33% of patients arrived by ambulance and the admission rate was 29%, which was a decrease of 3% from the previous year. In October 2018, no patients left the department without being seen and 6% of patients reattended within seven days of discharge.

This was an unannounced, focused inspection to review the safety of the emergency department as part of a focussed winter inspection programme. It took place between 1pm and 9pm on Monday 4 March 2019.

We did not inspect the whole core service therefore there are no ratings associated with this inspection. Our key findings were:

Our key findings were

- The emergency department (ED) was not always responsive to patients who presented with a high level of risk and we saw delays to assessment sometimes resulted in clinical deterioration.
- Staffing levels of paediatric-trained nurses overnight did not meet the minimum standards recommended by the Royal College of Paediatrics and Child Health (RCPCH).
- There were significant delays in most aspects of the service, including triage delays of over two hours and delays in awaiting specialist review of over 14 hours.
- Flow from the ED to the rest of the hospital did not meet demand and there was limited input from acute medical physicians. This reflected a culture in which not all specialty teams worked well together for the improvement of patient experience.
- Patients were regularly accommodated in corridors for extensive periods. This included elderly patients, those living with dementia and patients with mental health needs. Staff did not have the resources or facilities to deliver care with privacy and dignity.
- Overnight medical cover was often restricted to one doctor with higher specialist training at grade ST4 (specialist trainee) with one doctor at basic specialty trainee level (ST3). The service relied substantially on locum doctors, who formed 40% of the establishment. Staff said it applied substantial stress to the team.
- The ambulatory care unit was operating significantly above the capacity at which staff could effectively deliver safe care and delays in medical reviews exceeded six hours during our inspection.
- There were gaps in fire safety practice and training. We observed multiple examples of obstructed escape routes and partially blocked fire exits. Staff demonstrated highly variable knowledge of emergency procedures and described standards of training as poor.
- There was variable compliance with the Control of Substances Hazardous to Health (COSHH) Regulations (2002) and chemicals were not always stored safely and securely.
- Access to clinical areas was not controlled, including to the paediatric ED. This presented a safeguarding and security vulnerability to patients and staff.
- The ambulatory care unit (ACU) and acute medical unit (AMU) operated in a constant state of escalation, which placed additional pressures on staffing.
- Staff in paediatrics dedicated ED did not ensure that the audio-visual security system was routinely used.
- The trust had failed to act on an action plan issued in August 2018 to address several issues we found were on-going, including delays in decision to admit processes and security of the paediatric ED.
- The resuscitation unit operated effectively with senior decision-makers and senior nurses always present.

Summary of findings

- There was effective clinical collaboration between the consultant in charge and the nurse in charge and it was notable that staff systematically did their best in challenging circumstances.
- Staff demonstrated resilience and compassion when trying to help patients who experienced significant delays and expressed frustration. This included when they faced aggression and verbal abuse.
- The security team had wide-ranging responsibilities and provided considerable support, including in safeguarding and child protection circumstances.
- Leadership in the ED, ACU and AMU was consistently good and shift-leading nurses demonstrated supportive practice and well-developed competencies in reducing delays.
- The working culture empowered staff and promoted peer challenge as a strategy to deliver high standards of care and a strong work ethic. Although this was an overall finding the team in EDRU did not feel listened to or fully supported by the trust.

We told the trust they must:

- Improve performance in the national 15-minute triage recommendation, ensure triage processes meet national best practice guidance.
- Ensure adequate risk controls are in place for patients who wait extended periods for triage.
- Improve the effectiveness of internal professional standards for patients who need a specialist review and reduce delays in decision to admit times.
- Improve specialist review times.
- Improve standards of privacy and dignity for patients cared for in ED corridors and in the EDRU.
- Ensure fire safety controls and standards are fit for purpose in the ED, ACU and AMU.
- Ensure staff have adequate training and confidence in non-medical emergency procedures, including in evacuation plans.
- Ensure hazardous products and chemicals are stored in line with the Control of Substances Hazardous to Health (COSHH) Regulations (2002).
- Ensure patient's records are always stored securely and restrict access to electronic records to authorised staff.
- Staff in the paediatrics-dedicated ED must ensure that the audio-visual security system is routinely used.

In addition, the trust should:

- Improve governance processes andgovernance oversight of the streaming process to improve safety and reduce risk at the front end of the ED.
- Ensure there are enough suitably qualified doctors available in the ED overnight to meet patient need.
- Ensure the availability of paediatric-trained nurses in the ED complies with RCPCH recommended staffing levels.
- Ensure staff in EDRU have the competencies and ability to communicate appropriately with the relatives of patients.

There were also areas of outstanding practice:

- The responsiveness of the lead nurse in ED to surge situations resulted in a rapid reduction of triage delays in the department. For example, by redeploying existing staff they reduced the triage time from two hours to 17 minutes within a two-hour period.
- Staff were proactive in identifying opportunities for improved practice for patients with complex needs, including the use of multidisciplinary social care assessment pathways.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focussed inspection of the emergency department as part of a programme to assess safety during the winter period. We did not inspect any other core services or other locations provided by Wirral University Teaching Hospital NHS Foundation Trust. We visited the emergency department, the emergency department review unit, the ambulatory care unit and the acute medical unit. An urgent care walk-in centre was provided by another organisation and was not part of our inspection. However, we spoke with some of their staff to better understand the patient pathway and how the trust maintained oversight of patient care. We inspected using our focussed methodology, which did not look at all key lines of enquiry. We did not rate this service at this inspection.

Arrowe Park Hospital

Detailed findings

Services we looked at
Urgent and emergency services

Detailed findings

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Background to Arrowe Park Hospital

Arrowe Park Hospital is an acute hospital that is part of a number of services operated by Wirral University Teaching Hospital NHS Trust. The hospital serves a local population of around 330,000.

Wirral has the 66th most deprived population in England, which means it is not in the 20% most deprived authorities. Life expectancy for women is two years less than the national average and life expectancy for men is one year less.

From November 2017 to October 2018 the emergency department saw 96,668 attendances, of which 20,884 were children. Total attendances had decreased by 3% from the previous year. During this period 33% of patients arrived by ambulance and the admission rate was 29%, which was a decrease of 3% from the previous year. In October 2018, 0% of patients left the department without being seen and 6% of patients reattended within seven days of discharge.

Streaming services are provided by another organisation under contract from a Clinical Commissioning Group, which means patients may be directed to a GP and nurse-led walk-in centre operated by the other organisation. Our report considers care and treatment once patients are established as the responsibility of the trust, including when patients are in the emergency department but under the care of paramedics.

Our inspection team

The team included a lead CQC inspector, a second CQC inspector, a national professional advisor, and a clinical specialist advisor.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

How we carried out this inspection

Before our inspection we reviewed the data we held about the trust's national performance, including against Department of Health and Social Care four-hour wait targets. We also reviewed the latest data from the trust on mortality, admission and reattendance rates.

We carried out an unannounced, focussed inspection on 4 March 2019.

During this inspection we visited all areas of the emergency department including the reception and waiting areas for adults and children, majors and

resuscitation areas and the emergency department review unit. We included the ambulatory care unit and acute medical unit in our inspection to consider acute and urgent care pathways.

We reviewed 33 patient records to identify the amount of time people spent in the department and to review patient care. We reviewed the records of a further six patients being treated during our inspection. We attended two operational bed bureau meetings during the day of our inspection to understand how the trust managed capacity and flow.

We spoke with 39 members of staff representing a range of different grades and roles including staff who did not work for the trust but who provided services to their patients. We also spoke with 12 patients and relatives and we observed care and treatment being delivered.

Facts and data about Arrowe Park Hospital

The emergency department provides care and treatment to approximately 250 adults and children a day. Services are provided to both adults and children for medical and surgical emergencies and trauma.

Some areas of the department had been modernised. This included the reception area and waiting room, the triage and minor injuries area as well as the resuscitation and high dependency area. The majors area, children's area and the emergency department review unit are based in an older environment.

The department has three rooms to manage mental health patients, including a room for patients who were brought to the department by the police under a Mental Health Act Section 136 order. Mental health liaison services are provided by a local mental health trust.

We visited all areas of the emergency department including the reception and waiting area, the triage area, majors and resuscitation areas, the children's area as well as the emergency department review unit.

We spoke with 39 staff of different grades, including nurses, doctors as well as members of the management team from both the department and the wider division. We also spoke to staff from other areas of the hospital that had regular contact with the emergency department and with staff from other organisations who had responsibilities for the care of trust patients, such as paramedics.

We reviewed 33 sets of patient records for adults and children, including five prescription charts. We also reviewed information that was provided by the trust before and after the inspection. We spoke to patients and relatives about their experience and observed care and treatment being delivered.

At the time of our inspection the main Emergency Department (ED) was open 24-hours, seven days a week. Between 10am and 10pm patients are streamed before triage by staff from another organisation. The paediatric ED was open from 10am to 12am Friday to Sunday and from 9am to 11pm Monday to Thursday. The main ED and EDRU operated 24-hours, seven days a week. The ACU and AMU were open from 8am to 2am seven days a week although regularly opened 24-hours during times of exceptional demand.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

Safe	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

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The department has three rooms to manage mental health patients, including a room for patients who were brought to the department by the police under a Mental Health Act Section 136 order. Mental health liaison services are provided by a local mental health trust.

We visited all areas of the emergency department including the reception and waiting area, the triage area, majors and resuscitation areas, the children's area as well as the emergency department review unit.

The ambulatory care unit provides consultant and advanced nurse practitioner-led urgent care for minor illnesses and injuries to patients referred by their GP. The acute medical unit provides short-term inpatient care to patients from multiple medical and surgical specialties. We included the units in our inspection as part of the our standard urgent and emergency care reporting framework and because we wanted to check how the emergency department and acute medical unit worked together to improve access and flow.

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Urgent and emergency services

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

Our key findings were:

- The emergency department (ED) was not always responsive to patients who presented with a high level of risk and we saw delays to assessment sometimes resulted in clinical deterioration.
- Staffing levels of paediatric-trained nurses overnight did meet the minimum standards recommended by the Royal College of Paediatrics and Child Health (RCPCH).
- There were significant delays in most aspects of the service, including triage delays of over two hours and delays in awaiting specialist review of over 14 hours.
- Flow from the ED to the rest of the hospital did not meet demand and there was limited input from acute medical physicians. This reflected a culture in which not all specialty teams worked well together for the improvement of patient experience.
- Patients were regularly accommodated in corridors for extensive periods. This included elderly patients, those living with dementia and patients with mental health needs. Staff did not have the resources or facilities to deliver care with privacy and dignity.
- Overnight medical cover was often restricted to one doctor with higher specialist training at grade ST4 (specialist trainee) with one doctor at basic specialty trainee level (ST3). The service relied substantially on locum doctors, who formed 40% of the establishment. Staff said it applied substantial stress to the team.
- The ambulatory care unit was operating significantly above the capacity at which staff could effectively deliver safe care and delays in medical reviews exceeded six hours during our inspection.
- There were gaps in fire safety practice and training. We observed multiple examples of obstructed escape routes and partially blocked fire exits. Staff demonstrated highly variable knowledge of emergency procedures and described standards of training as poor.
- There was variable compliance with the Control of Substances Hazardous to Health (COSHH) Regulations (2002) and chemicals were not always stored safely and securely.
- Access to clinical areas was not controlled, including to the paediatric ED. This presented a safeguarding and security vulnerability to patients and staff.
- The ambulatory care unit (ACU) and acute medical unit (AMU) operated in a constant state of escalation, which placed additional pressures on staffing.
- Staff in paediatrics dedicated ED did not ensure that the audio-visual security system was routinely used.
- The trust had failed to act on an action plan issued in August 2018 to address several issues we found were on-going, including delays in decision to admit processes and security of the paediatric ED.

However:

- The resuscitation unit operated effectively with senior decision-makers and senior nurses always present.
- There was effective clinical collaboration between the consultant in charge and the nurse in charge and it was notable that staff systematically did their best in challenging circumstances.
- Staff demonstrated resilience and compassion when trying to help patients who experienced significant delays and expressed frustration. This included when they faced aggression and verbal abuse.
- The security team had wide-ranging responsibilities and provided considerable support, including in safeguarding and child protection circumstances.
- Leadership in the ED, ACU and AMU was consistently good and shift-leading nurses demonstrated supportive practice and well-developed competencies in reducing delays.
- The working culture empowered staff and promoted peer challenge as a strategy to deliver high standards of care and a strong work ethic. Although this was an overall finding the team in EDRU did not feel listened to or fully supported by the trust.

Urgent and emergency services

Are urgent and emergency services safe?

Clanliness, infection control and Hygiene

The service did not always control infection risk well.

There were substantial infection control challenges in the Emergency Department (ED) due to limited sluice facilities that did not meet demand and were damaged. Staff acknowledged this and it was included on the service risk register, but the only possible resolution noted was the construction of new facilities. During our inspection the sluice room in the ED was readily accessible to anyone in the area as staff did not adhere to the notices on the door instructing them to keep the area secured. Staff stored mops in buckets of dirty water and the floor, fixtures and plumbing were heavily damaged and hazardous cleaning products were stored in the room.

Cleaning checklists for patient bays and clinical areas and clear signage for specific barrier nursing techniques were in place in the ACU and AMU. We observed staff adhered to this guidance in practice and challenged visitors and colleagues when they presented a risk.

Environment and equipment

The service had suitable equipment which was easy to access and ready for use.

The emergency department (ED) had an eight-bedded resuscitation (resus) bay including one bay for paediatric resuscitation and one bay for major trauma. The majors area had 12 cubicles and was supplemented with a four-bay high dependency area with two rooms for isolating infectious patients. An assessment area had three bays for initial assessment, two triage cubicles, one cubicle for patients who could not easily wait in the main waiting area and four medical assessment cubicles. Staff designated one 'hot' cubicle in the area to start treatment for patients being accommodated in the corridor as a strategy to reduce delays.

Clinical equipment in the high dependency and resus units were set up identically to help staff work seamlessly between them during a shift. Staff used central monitoring equipment to monitor each patient in the areas from a single clinical staff base. This enabled multiple members of the clinical team to observe the monitoring data and clinical condition for all patients being cared for at that time.

There were three designated rooms for patients with mental health needs, including one room for patients cared for under a Mental Health Act Section 136 authorisation. The rooms were free from ligature risks and provided a calmer, quieter environment for patients with a high degree of sensitivity to light, noise and being in a busy environment. One room was en-suite and there were adjacent toilet facilities for the other two rooms.

The ambulatory care unit (ACU) had 20 chairs and space for five trollies and the acute medical unit (AMU) had capacity for 18 patients on trollies or beds.

The resus area was well equipped and suitably staffed. Staff had immediate access to trust and national care pathways, such as for stroke, and rapid access to diagnostics such as computed tomography (CT) scans. During our inspection staff acted quickly to order CT scans and reports and the business of the main ED did not impact negatively on the consistent standards of the resus team. X-ray facilities were available 24-hours and were linked to the ED through a direct corridor.

It was common practice for the ED team to provide care for patients on trolleys in up to three corridors due to a lack of space. There was not enough space to use privacy screens, which compromised the dignity of patients undergoing examination in the corridor. This also meant there was no space for private discussions. Throughout our inspection staff struggled to organise the space logistically and safely due to the volume of patients and the amount of equipment present. We saw nurses completely block exit routes and corridors whilst trying to manoeuvre patients on trolleys and beds. This was always temporary whilst they organised the environment but it presented an elevated risk. The trust had installed electrical outlets in three corridors regularly used to provide care, which meant staff could more readily use monitoring and clinical equipment.

There was sufficient equipment such as adult, infant and paediatric pulse oximeters, blood pressure machines, thermometers, oxygen and suction for the number of

patients requiring these. Patients in cubicles had access to call bells to call for staff if required. However, there were no mobile call bells for patients cared for in corridors.

A medical device link nurse was in post and attended training sessions with the medical devices team to be able to deliver consistent support and guidance to colleagues in the ED.

Staff had access to sepsis toolkits. These were ready-made boxes which included sepsis step by step guidance and all the items required to deal with a suspected sepsis patient quickly, such as medicines and fluids. A sepsis lead nurse was in post and a recently-appointed educator provided support for all staff in sepsis pathways.

Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys, which were sealed with a tamper evident tag. Staff carried out daily safety checks, which we noted reflected improved practice from our last inspection.

All staff were aware of the location of the emergency equipment and how to use it. However, non-clinical staff responsible for streaming had minimal training in the use of emergency equipment and were not trained in the use of defibrillators.

Clinical areas were not fully compliant with the Sharps Instruments in Healthcare Regulations 2013 and the Department of Health and Social Care (DH) Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste. In the EDRU, three sharps bins in a patient area were overfilled, with syringes and sharps visible and stopping the lids closing. There were two similar sharps bins in the AMU, which presented a risk to children or patients with reduced mental capacity. We spoke with staff in EDRU about this who said it was not their responsibility to monitor sharps in this clinical area as it was used by the ED team. This meant there were not local, robust procedures in place to clearly assign responsibility for importance safety tasks to staff.

The dedicated paediatric ED was equipped with an audio-visual security system that staff could use to restrict access. At our last inspection in May 2018 we found staff did not routinely or consistently use the security system and we told the trust they should address this issue. The trust included this in an action plan for improvement in August 2018 with an action that the paediatric ED be secured with staff-controlled access at all times. However, during this inspection the security system was disabled and there was unsecured access to the area. This presented a safety and safeguarding risk to children. We asked staff about the security system and they said it did not need to be used as the team was always present to monitor people in the area.

There was no dedicated paediatric waiting area overnight, which presented a risk young children would need to wait in the main waiting room with adult patients. Triage nurses used a safeguarding assessment during triage to identify risks to patients and ensured they were accommodated in a separate area if needed.

There were substantial risks to staff, patients and the environment from inconsistent and substandard fire safety management. We observed it was common practice across all areas we inspected for staff to wedge open automatic fire doors or doors marked with 'Fire door, keep shut' signs. There was limited space for storage in the main ED and in AMU and staff used corridors to store equipment and combustible materials. This would impede a safe and rapid evacuation in an emergency. In the ED a fire exit was damaged and forced to remain open on a latch despite being marked with signage that noted opening the door would set off the fire alarm. The area outside of the fire exit was littered with cigarette butts and a chair and ashtray were in situ despite notices instructing staff and visitors not to smoke in the area.

We spoke with a senior nurse about fire safety who said the trust was in the process of updating local health and safety processes. They said a fire warden was in place but had not had advanced training and they were trying to secure this. The trust had not provided practical fire safety training or evacuation training to any staff. We asked nine individuals about the procedure they would follow in the event of a fire or evacuation event and each individual provided a different understanding of local arrangements, including who was ultimately responsible for evacuating.

During our inspection a relative of a patient in the EDRU made a complaint about the poor cleanliness of the patient's room. They were concerned that debris from clinical disposables, including a used syringe, had been

left on the floor all day and that surfaces were dirty and dusty. We found overall cleanliness in the EDRU did not meet an acceptable level. One clinical room was used to store equipment and there was discarded packaging on the floor and around equipment. The kitchen in the unit had a wholly unacceptable level of cleanliness. Although a notice was displayed instructing people to label their food with a date for hygiene and infection control purposes, this was largely ignored. Surfaces were stained with dried liquid spillages and there was food debris on the floor and countertops along with a putrid smell. We spoke with staff about this who said it was unclear whose responsibility it was to clean the kitchen, which meant it often did not get cleaned on a daily basis.

We found staff in ED and the AMU did not routinely secure storage areas for cleaning chemicals despite notices on storage area doors stating this as a local safety requirement. Following our last inspection in 2018 we told the trust to improve the safe management and storage of chemical products. In February 2019 the central alerting system (CAS) issued an alert regarding risks to patients caused by unsecured storage of cleaning chemicals. We did not see evidence the trust had implemented and sustained improvements in relation to our previous inspection or in relation to the CAS alert. After our inspection the trust provided details of an implementation plan to address the issues, which was on schedule to be completed by May 2019.

During our inspection the waiting room was frequently filled to capacity with limited crowd control from staff. At busy times people had to stand or sit on the floor. Although vending machines were in situ there were no facilities for people to obtain fresh drinking water. However, ED staff recognised the challenges with crowding and provided vulnerable patients, such as the elderly, with snacks and drinks.

A dedicated security team provided on-call cover 24-hours, seven days a week. The team stayed with patients who presented with a risk of violence to others and met paramedics who called ahead and were concerned about a patient's behaviour. ED staff frequently asked the security team to monitor patients who had the behaviour potential to create risk for themselves and others, using a CCTV system but security officers raised concerns about the poor quality and functionality of the system. In addition, the system did not cover all areas used for patients who presented with risks of violence.

Assessing and responding to patient risk

Risks to patients were not always assessed promptly and they were not consistently supported to stay safe.

Clinical staff did not have appropriate oversight of the condition of patients presenting in the department. This was because there was not always a clinical member of staff, such as a nurse practitioner, based permanently with the reception team, which was provided by another organisation. Although a nurse was based at the front desk at times during our inspection, this was sporadic and they did not play an active role in patient streaming.

An ambulance triage nurse and a clinical skills nurse were based in the corridor when this area was used to care for patients and coordinated clinical care. This team risk assessed patients and made decisions about where they could be most safely cared for in the various areas of the department. We observed other staff from the department review patients as needed, including the resuscitation team when they were not needed in resus. Although this meant patients in the corridor had clinical supervision, it did not address the risks to patients accommodated in another two corridors. The department used these areas for additional capacity during times of high demand but could not provide staff to deliver care when second and third corridors were used. When these areas were used to accommodate patients, trust nurses or paramedics remained with them without the use of ED clinical equipment or monitoring. The service recognised this in the risk register although this had not identified a resolution.

When patients first arrived in the department on foot, a community nurse and team of non-clinical staff who worked for another organisation carried out a streaming process. Based on the patient's presenting condition the team would direct patients to an on-site GP walk-in centre or add them to the ED list. However, all the doctors and senior nurses we spoke with raised concerns about this model and said they felt it was unsafe. One clinician said, "It is inherently unsafe. It makes the department dangerous and we shouldn't be taking risks like this." The

community nurse was present intermittently during our inspection and senior staff said they were available daytimes only with no cover when they took a break. However, we observed the ED nurse in charge provided a point of contact for the reception team and provided guidance as needed to reduce risks to patients who would become the responsibility of the trust. For example, the ED lead nurse provided support when a patient presented with suspected measles. Triage staff found two patients waiting to be seen who were experiencing chest pains, which had not been documented by the streaming staff. This presented an avoidable risk to both patients and meant they waited longer to be seen than was clinically needed.

Senior nurses said the streaming team regularly mis-directed patients and GPs sent patients back to the ED. However, as a precautionary measure the ED team worked to a policy of never redirecting patients back to GPs. Although this extended waiting times staff said it reduced the risk caused by extended delays to patients for assessment.

Royal College of Paediatrics and Child Health (RCPCH) standards state that all children should be visually assessed by a doctor or nurse and have a clinical assessment within 15 minutes. There should also be an escalation policy if triage wait exceeds this as delays can have serious consequences, especially for young children. The ED met these requirements during our inspection.

The triage system was nurse-led and took place in a dedicated triage assessment area for patients who presented on foot and for those brought to the ED by ambulance. During 'surge' periods, when the department saw a significant and sustained increase in patient demand, the department allocated additional nurses to the triage process. During our inspection the lead nurse in ED increased the triage team to three nurses, which reduced triage time from two hours to 17 minutes. Due to demands on the service, we observed a significant delay in patients being seen by a doctor during peak times. At one stage in our inspection the longest wait for a doctor was over three hours in ED and over six hours in the ACU.

We looked at a sample of 33 patient records, including five patients in resus and five patients in the paediatric ED. In resus and the paediatric ED all patients were triaged within 15 minutes of arrival and there was evidence of a timely senior review by an appropriate doctor. In most cases staff had documented information clearly with their name, grade, time and signature. In seven records staff had not noted the time of first medical review.

Patients received a comprehensive assessment in line with clinical pathways and protocols. Patients were assessed using a combined form which contained a medical admission and nursing admission template. This included sections for clinical observations, the Glasgow coma scale and details of past medical history, complaint history and a section for treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations. We reviewed nine records to check the standard of completion, including the patient safety checklist, which was a critically important document. In two out of nine cases we found incomplete checklists and pathways that had not been started, including two missing sepsis pathways.

The modified early warning score (MEWS) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). We looked at 19 MEWS charts in ED and AMU and saw that they were completed correctly and regularly updated. MEWS is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. On the charts reviewed, clinical observations were repeated in line with the previous score and escalated when scores were elevated.

Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. We looked at the records of 10 patients in the department who had the sepsis pathway implemented. All charts we reviewed showed diagnostic and initial treatment was completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) Sepsis: recognition, diagnosis and early management.

Nurses completed life support training at a level commensurate with their experience and level of

responsibility. At the time of our inspection 100% of nurses had up to date training or were booked onto a course imminently, with a confirmed date and protected time.

The education facilitator nurse was leading a programme to increase the number of nurses trained in immediate life support (ILS), advanced life support (ALS) and paediatric life support (PLS). All senior nurses had completed PLS training and there was always a PLS-trained nurse available in resus. This was a new post made permanent after a successful pilot and meant staff had more consistent access to training and development. The nurse had introduced structured training in the Manchester triage system to improvement initial assessment and risk management of patients. While this was not fully embedded we found improvements since our last inspection in May 2018.

Staff with ILS and ALS certification had completed training to transfer patients to the critical care unit with a defibrillator.

Staff demonstrated good understanding of safeguarding principles although the crowded nature of the department and unmonitored access presented significant safeguarding risks. We spoke with a security officer who said their team was often called upon to assist in child protection cases where staff were concerned about the behaviour of parents in the department.

Staff carried out regular safety huddles to review the capacity of the department and address immediate risks to individual patients. We attended a safety huddle as part of our inspection.

The team had a good understanding of the key pressures and patients most at risk.

Nurses used a mental health risk assessment and pathway to provide structured care to patients who presented with a mental health need. The team used this to assess patients for levels of risk when all three mental health rooms were full in the ED, which helped them to identify appropriate areas to care for patients whilst minimising risk.

Reduced paediatric emergency care overnight was included in the service risk register and the education facilitator was increasing the number of adult nurses with paediatric training.

A dedicated team led care in the resuscitation unit and there was always a consultant and senior nurse present. We observed good management of patients in line with trust and national guidance, including for sepsis and chronic obstructive pulmonary disease (COPD).

ED staff noted risks with the corridor system and said nurses from the trust rota allocated to corridor care were often inexperienced in urgent and emergency care and required substantial supervision and support. The trust used an 'alerting mechanism' for patients cared for in corridors to ensure ED nurses maintained oversight of each individual's condition. For example, staff on a trust rota carried out rounding on each patient to assess them for dehydration, malnutrition and toileting needs. However, this team were unable to provide direct practical help to patients and instead reported to ED nurses who then had to carry out the tasks. Nurses in the department described this as "very challenging" and said it created additional pressure for them. One senior nurse said, "The trust accepts overwhelming pressure on us and provides no tangible support. Sending unqualified staff to act as a go-between when patients are in the corridors does nothing to improve care or to help the clinical team." All ten doctors we spoke with said they felt corridor care was unsafe and compromised patient privacy, dignity and risk management. During our inspection we observed patients spend lengthy periods of time in the corridor. Staff carried out private discussions with them and physical examinations discreetly but without the use of curtains or other barriers, which compromised privacy and dignity.

Patients in the AMU frequently had complex social needs in addition to their medical needs. To manage the risks associated with this, acute physicians worked with community colleagues and the hospital's discharge planning team to ensure patients only left the hospital when they had an appropriate package of care. We saw effective use of the Department of Health and Social Care fastrack pathway for continuing healthcare as a tool to support the team in this. Staff implemented this pathway when a patient's condition deteriorated and they were not safe to be discharged without social support in place.

The paediatric ED team had introduced a new threshold pathway to help clinical staff identify safeguarding and child protection risks at the point of triage. This represented an improvement in the existing system and meant staff could rapidly escalate care to specialist services, including community services, where young people presented with significant risks including from suicidal intent and sexual exploitation.

We were not assured there were adequate resources or staffing for patients who presented with a mental health condition. We found paramedics were required to stay with patients in corridors and provide nursing care to them in the mental health rooms due to a shortage of nurses to provide a handover.. However, a dedicated clinical support worker was in post and provided a liaison between ED staff, the mental health team and others involved in care, such as paramedics. They provided care to patients until they could be assessed by the medical team and the mental health team. Although this provided additional capacity, staff said this did not always feel like a safe role and the support worker had asked to be relieved on occasions when patients presented with violence or inappropriate threatening behaviour.

In January 2019 the EDRU had the highest rate of falls in the hospital at an average of 10 per 100 patients. We observed the environment to be busy, noisy and cluttered although each patient had a falls risk assessment in place.

A lead nurse for Chemical Biological, Radiological and Nuclear (CBRN) incidents was in post and carried out regular stock checks of the equipment on site. However, staff did not have access to regular training in CBRN scenarios and the use of equipment and the department did not track which members of staff were competent in the use of specialist equipment on a shift-by-shift basis.

Nursing staffing

There were not always enough nursing staff to keep patients safe from avoidable harm and to provide the right care. Nurses had the right qualifications, skills, training and experience.

The emergency department used a combination of the baseline emergency staffing tool and the NICE emergency department staffing recommendations to ensure the department was staffed appropriately. This outlines how many registered nurses they needed to safely staff the department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. Nurses with more advanced roles, including emergency nurse practitioners and advanced nurse practitioners, formed part of the nursing team.

The ED was fully recruited to its establishment of nurses and the senior team had introduced a policy that recruited new staff on a like-for-like basis when existing nurses left.

There were always two trained nurses in resus, which met the nurse to patient ratio standard of 1:2 set by the Royal College of Nursing.

At all times during our inspection, we found the skill mix of staff to be suitable for the needs of the ED, with actual staffing levels meeting the planned levels. Senior staff had oversight of staffing in the department and moved staff around to ensure all areas were safe and they were able to manage surges in demand. However, this did not always apply to patients being cared for in the corridor.

Nurses did not have appropriate training to be able to care for patients who presented with acute mental health needs. Staff in the ED and in AMU said they frequently saw younger patients who had overdosed intentionally or who were at risk of suicide and security officers said they regularly provided support for clinical staff caring for young people who presented with intoxication.

The paediatric ED was open and staffed by nurses with paediatric training from 10am to 12am Friday and Saturday and from 9am to 11pm Sunday to Thursday. This always included a senior nurse and a staff nurse as a minimum, which met recommendations from the Royal College of Paediatric and Child Health. However, overnight the service was unable to provide continuous cover by paediatric-trained nurses. The education facilitator nurse was leading a training programme in paediatric urgent care, which would result in all senior nurses in the ED holding paediatric competencies. This represented a significant improvement in nurse cover for children.

A senior nurse and a care support worker (CSW) were dedicated to care for patients accommodated in the mental health rooms. This team were part of the core ED staff rota and were redeployed when patients were admitted to the mental health area.

Emergency care support workers were assigned to corridor care on each shift and supported nurses in patient monitoring. The service had introduced an additional two care support workers on each shift in the ED to improve patient care.

Emergency nurse practitioners led care in the minors unit from 8am to 12am seven days a week. Outside of these hours doctors provided cover.

Children's nurses from the paediatric assessment unit (PAU), which was separate from the ED, provided supported to ED colleagues during times of high demand. This was especially important when the ED had a shortage of paediatric nurses. However, PAU staff told us at weekends they were often required to help colleagues on the inpatient children's ward instead and they felt this left the ED team vulnerable.

There were seven whole time equivalent (WTE) nurse vacancies in the AMU, which impacted the service as the unit had also operated on a 24-hour basis for several weeks despite not having planned staff cover for this. However, senior staff said recent recruitment events and improved relationships with the human resources team meant acute medicine had started to experience improved recruitment. For example, one recruitment event had resulted in the acceptance of nine new nurses into the division.

Nurse cover in the ACU and AMU was scheduled until 2am and when patients were accommodated overnight the trust assigned bank staff and redeployed nurses from various medical wards. Staff said this was a challenging system because it meant there were often a lack of acute medical nurses available overnight and nurses from other areas of care would be reassigned instead. After our inspection the trust provided the nurse rotas and staffing tool for day of our inspection and the next day. This showed a shortage of CSWs and redeployment from another ward but the safer nursing tool demonstrated safe levels of nurses were on duty. However, staff on duty during our inspection said staffing levels were not always safe and cover over night was sometimes provided by nurses from other specialties without the skills to provide a full range of care to acute patients.

Nurses coordinated care and adapted to demands on the service and unplanned staffing issues during daily safety huddles. This helped the team to work flexibly and we saw nurses of different grades were able to redeploy to ensure safety in key areas.

Medical staffing

There were not always enough medical staff to keep patients safe from avoidable harm and to provide the right care. Medical staff had the right qualifications, skills, training and experience.

Senior medical staffing levels in the ED were adequate to meet demand during daytimes. A team of 12 whole time equivalent (WTE) consultants and one associate specialist provided care from 8am to 12am Monday to Friday. This met the Royal College of Emergency Medicine (RCEM) recommendation of a minimum of 16 hours on-site consultant cover per day. At weekends consultant cover was from 9am to 12am, which did not meet the RCEM recommendation. One consultant was always on-call overnight and able to travel to the ED within 30 minutes. All consultants were registered on the General Medical Council (GMC) specialist register. Fifteen locum doctors of varying grades, including four locum GPs, provided cover for staff shortages and had completed inductions and had appropriate access to support. Overnight medical cover by middle grade doctors was good but only one ST4 (specialist trainee) doctor or one ST5 doctor from intensive care was available. This meant there was limited input from senior decision-makers. We looked at the doctor rotas from 11 February 2019 to 3 March 2019 and found the number of middle grade doctors on shift between 1am and 7am varied from one to three doctors with support from up to seven junior doctors. Locum doctors regularly made up this figure and on one date during this period no middle grade doctors were available and a consultant worked alone. In addition, we found it was common practice for a single specialist registrar to be on shift during weekend daytimes, which was a substantial shortfall in the senior-level numbers needed to provide safe care. After our inspection the trust told us medical staffing levels overnight reflected an improvement from five doctors to eight doctors for the winter period.

A paediatric consultant was available in the paediatric ED at all times the unit was open. Overnight the on-call paediatric consultant from the children's inpatient wards provided on-call cover for emergencies.

A consultant or specialist registrar provided care in the AMU from 8am to 9pm seven days a week. The trust used the unit frequently for extended inpatient stays and overnight admissions. However, overnight there was no dedicated medical cover and the nursing team relied on the on-call medical registrar who was also on-call for all inpatient medical services. The trust had recently improved out of hours registrar cover, which meant there were two doctors available overnight.

Junior doctors spoke positively about working in the emergency department. They told us consultants were supportive and always accessible and they felt opportunities for learning were readily available.

Middle grade doctors said that except for the issue with night cover, they were happy working in the department and felt they had adequate senior support and had received a good induction.

Doctors described a continuous culture of teaching supported by the clinical lead and consultants.

An acute physician of the day led medical care in the AMU and ACU and led a daily safety huddle with consultants to review each patient in the unit. This meant the team could identify patients for discharge and those who were sick and needed further review or admission to a medical specialty.

ED consultants were responsible for patients in the EDRU. Where patients were admitted to the unit as medical outliers, the consultant from their clinical specialty included them in ward rounds. For example, nine patients in the EDRU had been admitted there as outliers due to a lack of capacity in wards. The ED consultant provided as-needed care and the medical team from the patient's specialty carried out ward rounds and reviews as needed. A foundation year one doctor was based in the EDRU from 9am to 5pm seven days a week.

Consultants led twice-daily ED board rounds with the medical team and senior nurse team to review all patients in the department. We attended a meeting and saw it was well-attended and effectively structured to manage patient needs and risks.

Specialist trainee doctors at grade ST4 or above on shift overnight were required to hold advanced life support certification.

We observed consultants and senior doctors were supportive of junior colleagues and made themselves readily available. During a board round the consultant lead actively involved junior doctors and ensured they understood the plan for each patient. The senior team communicated important messages to junior colleagues and ensured this formed part of the patient's treatment plan.

Records

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

The electronic patient record system time-stamped triage activity although staff did not routinely record the triage time in paper notes. This meant it was not possible to immediately establish the length of time between arrival and triage for patients. We reviewed the medical notes of seven patients and looked at key times during their stay in ED. One patient waited three hours and 15 minutes to be reviewed by a doctor and the second patient waited 21 minutes. The first patient waited 13 hours and 55 minutes to be admitted to the hospital and one patient waited 10 hours and 11 minutes.

We reviewed the records of 20 patients who had been treated in the ED in the previous 48 hours. Patients in the sample waited an average of 57 minutes for triage, with a wide variance from one minute to 151 minutes. In six of the records staff had not documented the time of the first medical review.

Are urgent and emergency services caring?

Compassionate care

Staff did not always care for patients with compassion.

Staff in ED said they were unable to meet patient needs when they were accommodated in the corridor. For example, one nurse described a situation in which they provided care to a patient who had overdosed and was

unable to carry out a confidential, private assessment of their needs due to overcrowding. The ED team staffed the first of three corridors regularly used for patient care. Where there was a need to use the second and third corridors staff allocation was less consistent. For example, the site operations team used a trust rota to allocate nurses when the second corridor was used. When the third corridor was in operation paramedics were required to stay with patients. We spoke with five paramedics about this. They said during daytimes up to 6pm they would normally be relieved by trust staff within two hours but outside of these times it was typical to wait up to five hours. They described the corridor care as, "very undignified." The corridor in which paramedics led care for ED patients was not wide enough to carry out transfers using pat slides, which presented a safety risk and meant patients remained on trollies for extended periods of time.

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

Access and flow

Patients could not always access the service when they needed to.

There were systems in place to manage the flow of patients through the emergency department (ED) to discharge or admit to the hospital but these did not function adequately or consistently. There was limited communication between acute physicians and doctors from medical specialties and the ED team, which resulted in considerable delays in admitting patients to medical and surgical wards. We found evidence of this through our discussions with ED consultants, our attendance at two bed bureau meetings, discussions with acute physicians and our review of decision to admit times.

The operations control room and clinical site team could see on the IT system the length of time patients had been in the ED, who had been referred and who was awaiting admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. The team discussed this at regular bed bureau meetings throughout the day and made plans to address it.

The ED clinical lead, director for capacity and nurse coordinator worked together to identify patients waiting for admission or transfer. We saw evidence of effective communication amongst this team during our inspection. Associate directors of nursing worked closely with ED and AMU colleagues during busy times to support flow. However, there was limited action identified at the meetings to address issues of flow through the department due to lack of beds on wards. For example, there was a clear focus on the work of the ED team to reduce triage times and the wider site team to find beds, there was not a focus on reducing decision to admit times.

The ambulance triage nurse saw each patient who arrived by ambulance and was subsequently cared for in one of three corridors during times of high demand. Staff moved patients to the initial assessment unit once space was available. Staff maintained one empty assessment bay in the initial assessment area to be able to carry out tests and examinations on patients who were in the corridor.

The service used the NHS England operational pressures escalation levels framework (OPEL) to measure pressures on the service. However, there was limited focus on OPEL from the site management and capacity team during our inspection and senior clinical staff said the department always operated at OPEL 3. OPEL 3 means that the trust is experiencing major pressures compromising patient flow and the number of patients requiring treatment continues to increase. This meant there was no structured change in operational management in response to periods of surge or unexpected demand. Staff did not discuss the OPEL status of the hospital during the bed bureau meetings we attended.

We attended two bed bureau meetings and saw site and clinical teams used a continuous review of specific patient groups to coordinate flow. This included maintaining lists of patients living with dementia to avoid bed moves wherever possible and prioritise specialist review in the ED. The team also monitored outliers, stranded patients and 12-hour breaches in the ED. NHS Improvement defines a stranded patient through the emergency care improvement programme as a patient with a length of stay of seven days or more.

The director for capacity was responsible for managing flow from 8m to 6pm Monday to Friday with support from

the medical care manager of the day, which rotated through the associate directors of nursing team. The team had changed the structure of bed meetings in the previous three months by removing matrons from the process. An associate nurse director said this was to enable matrons to focus on clinical care and coordination in their specialist areas. The discharge team were proactive in identifying opportunities for appropriate transfers and in progressing proposed and definite discharges. At 6pm on the day of our inspection the ED had seen 191 patients and 46% had breached the national four-hour target.

Consultants described considerable difficulty in maintaining access and flow from the ED to medical specialties. The clinical lead said there was typically 20 patients waiting for admission in the ED each morning with patients waiting for a decision to admit for over six hours. One consultant said, "There is no structure or professional standards in place. It is not a functioning system." We saw evidence of this throughout our inspection and at one point there were 28 patients waiting for an inpatient bed but only 16 had a confirmed decision to admit in place. One patient had received a decision to admit after 10 hours in the department and waited another 11 hours for a bed. A patient flow improvement group was in the process of identifying opportunities to improve this.

In January 2019, 42% of patients waited from four to 12 hours from the decision to admit to admission time. This was a deterioration from 27% in January 2018 and was worse than the national average of 20%.

In December 2018, the trust's monthly median total time in A&E for all patients was 1.3 hours, which was worse than the England average of 1.1 hours.

In December 2018 the median time to treatment in the national data set was 74 minutes compared to the national average of 60 minutes.

The Department of Health and Social Care sets a national standard that all patients who present to an ED should be seen and assessed and admitted or discharged within four hours. In January 2019, 62% of patients spent less than four hours in ED. This was a deterioration from 71% of patients in January 2018 and was much worse than the national average of 79%.

A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the ED until they are handed over to staff. In January 2019, the performance for type 1 was 62% which is much worse than the national standard and worse than the national performance of 76% and worse than the previous January 2017 (71%).

In January 2019, 12% of ambulances remained at the hospital for more than one hour. This was better than the previous performance of 18% in January 2018 and worse than the national average of 8%.

In December 2018 the average time from arrival by ambulance to initial assessment was 19 minutes, which was slightly better than the average of 22 minutes in December 2017.

A member of the divisional leadership team was always available on-call and responded to surge periods, when delays and breaches increased. For example, the on-call manager liaised with the local ambulance service and worked with on-site clinical leads to reduce the risk of 12-hour breaches.

The paediatric ED team could refer patients to the community adolescent mental health service (CAMHS) for urgent next-day appointments where teenagers presented with alcohol or drug overdose.

Patients accessed the ambulatory care unit (ACU) on referral from their GP and on a follow-up basis where they had previously been cared for in the hospital. The service was led by a consultant and an advanced nurse practitioner (ANP), which meant patients could be reviewed for a wide range of medical conditions. ANPs were qualified prescribers, which reduced the need for patients to see a consultant for less serious conditions. Patients were transferred to the acute medical unit (AMU) directly from ED where they needed further care and assessment. Staff used this as a strategy to reduce the impact of delays while awaiting review from medical or surgical specialties. However, the hospital consistently operated at over 99% capacity and patients often spent lengthy periods of time in the ACU and AMU, including in daytime clinic rooms that were used for overnight accommodation.

Urgent and emergency services

The clinical governance team identified access, admission, transfer and discharge as key themes in the ED and during bed meetings in November 2018 and December 2018. We saw evidence of this from reviewing the minutes of meetings.

Staff in the ACU had access to the live ambulance call-out and arrivals system, which replicated the emergency system used in ED. This meant the clinical team could prepare for patient arrivals and prioritise care for those with the most urgent needs.

ED consultants did not have the authority to implement decisions to admit and instead had to wait for a review from colleagues in other specialties. This caused significant delays. For example, at one stage of our inspection there were 28 patients waiting for a hospital bed, of which only 16 had a decision to admit. One patient had been in the department for over 17 hours with a decision to admit made over eight hours previously.

The emergency department review unit (EDRU) was designed to provided short-term observation and care for a maximum of two days. Staff worked closely with ED colleagues and were trained to provide care for patients with conditions such as alcohol dependence, minor injuries and anaphylaxis. However, a lack of capacity across the hospital meant the site team frequently accommodated medical inpatients in the EDRU. Staff said patients often spent up to seven days in the unit and although they were appropriately staffed, this reduced the capacity of the unit to provide support the ED.

Senior ED staff raised concerns about of access and flow processes from the on-site walk-in service and said the streaming process exacerbated this. For example, a senior nurse said it was common practice for GPs to escort patients who had been inappropriately streamed to their service back to the ED and leave them in inappropriate areas, such as initial assessment, room without a structured handover.

A team of physiotherapists and occupational therapists were based in the ED seven days a week as part of a broader strategy for admission avoidance. Specialists in musculoskeletal (MSK) injuries and conditions and respiratory problems worked alongside the nursing team to provide rapid assessment. This team were trained to coordinate discharges and work as part of a wider team to lead on community care planning and secure packages of care. This meant patients who had more complex social needs were assessed, treated and discharged without delays caused by waiting for medical review.

Specialist nurses for older people (SNOPs) were based nearby to ED and provided a dedicated referral and in-reach service. This meant where patients presented with conditions relating to frailty and dementia, the team provided a rapid assessment service. This reduced delays for these patients waiting in the ED.

The ACU acted as a single point of entry for patients referred by GPs and 60% of patients referred in this way were discharged from the hospital within 24 hours.

Are urgent and emergency services well-led?

Leadership

Managers at all levels in the trust demonstrated the right skills and abilities to run a service providing high-quality sustainable care.

The consultant in charge of the emergency department (ED) was capable of managing critically ill patients and supervising the junior doctors. There was good communication between the consultant in charge and the nurse coordinator; however, a lack of co-ordination with the site team and medical specialties was evident. The senior management team were present in the department and provided support during peak times.

Staff in ED spoke positively about local leadership. The said the new manager and matron were approachable and always ready to help. They said that although the department could be a challenging place to work because of crowding and the lack of flow, they never felt alone without a senior member of staff to help.

An ED manager and matron had recently been recruited, which represented an improvement in leadership structure and availability since our last inspection in May 2018.

Staff described associate directors of nursing, the medical director and other senior staff as visible and approachable. Senior nurses said they felt well supported and we saw this team were confident and empowered during bed meetings.

We observed effective leadership from the charge nurse in the ED during our inspection. For example, by redirecting an emergency nurse practitioner from clinical duties to the triage process they reduced triage delays by one hour and 40 minutes within a three-hour period.

Staff described a new system of 'culture-based leadership' with the implementation of a new matron and ED manager. For example, a senior nurse helped to redesign the interview process for nurses seeking promotion and said this helped the team to work more closely with senior colleagues.

Vision and strategy for this service

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. However, this was not replicated by a clear and robust local vision for ED.

Senior staff acknowledged a need for more effective care pathways that linked services together, such as the ED team with the mental health liaison team and wider medical specialties.

The ED senior nurse described the work the division had completed to improve internal professional standards to reduce delays in admitting patients. The work meant patients in some specialties could be sent directly to assessment units or wards without the need to wait for specialist review. We saw this worked well in practice, such as with a patient who the triage nurse coordinated a transfer to the maternity ward. Although this reduced delays for patients with minor conditions, there were significant delays in patients accessing review by consultants in some specialties.

At one point during our inspection the longest wait for a hospital bed for patients in ED was 10 hours 12 minutes and for patients in the ambulatory care unit (ACU) it was three hours 13 minutes. This demonstrated the challenges ED staff encountered in securing decisions to admit from other specialties.

The matron for ED had developed a department-specific values statement with the team that helped them to identify how they could contribute to the delivery of the trust's overarching vision and strategy. Nurses we spoke with demonstrated a clear understanding of the values and said they felt it helped them to deliver high standards of care. However, there was no clear vision or strategy for the department from the consultant team and the clinical lead did not have a well-defined role in departmental development. For example, senior clinicians were knowledgeable of the challenges and risks in the department but did not have articulated plans to address them.

Doctors described a significant improvement in their relationship with the trust board and senior management team in the previous 12 months. They said they felt part of the trust's mission and aims but felt without a substantial overhaul of processes and investment there would be limited improvements in practice.

Governance, risk management and quality measurement

The trust used a systematic approach aimed at continually improving the quality of its services and safeguarding high standards of care. This was not consistently effective.

The streaming service was operated by another organisation daily from 10am to 10pm. The ED leadership team had limited oversight of streaming protocols and the training of the team. All of the doctors and several other staff spoke with us about safety concerns in this arrangement.

We observed a good working relationship between the ED team and paramedics from the local ambulance service. Senior staff said teams from both organisations were working together through joint governance structures to identify more effective ways of working together.

Consultants, middle grade doctors and junior doctors held mortality review meetings monthly. Doctors said these were effective in reviewing care and identifying opportunities for improvement and in establishing improved care pathways This had recently resulted in the implementation of a new self-harm pathway.

Urgent and emergency services

As part of our inspection we looked at the minutes from the three most recent governance meetings that took place from November 2018 to February 2019.We found a consistent focus on risks, performance, quality of care and staffing with a range of staff groups represented. The minutes provided limited evidence of established governance between the trust and other organisations responsible for delivering care to their patients.

Staff responsible for delivering care in ED said they were not aware of any governance processes between the department and the provider responsible for providing mental health services. They said patients usually waited for extended periods of time to be seen by mental health specialists. Where patients presented with medical needs relating to alcohol or drug overdoses, ED staff had to provide care and treatment until the patient was sober and medically fit before mental staff could see them. This added substantial pressure to the team and they said there were no mechanisms in place for them to discuss this with mental health team colleagues.

Similarly, senior staff in the department described "very limited" oversight of or communication with the team responsible for streaming their patients. This meant there was a risk the team responsible for delivering care and treatment did not have clear lines of contact with other organisations providing services to their patients.

Additionally, staff said they did not routinely report incidents involving staff from other organisations to the trust, which meant there was little overall and accurate understanding of performance and risk management in these areas. For example, one senior nurse said, "I'm often worried about the lack of safety around the streaming process. But I wouldn't necessarily report it. I'd escalate it to the [associate director of nursing on call] but I don't know that they do anything about it." The clinical lead attended governance meetings with the provider of the streaming service, which meant there was a substantive link between the organisations despite not all key staff being aware of it.

Divisional staff used a risk register to identify and track risks to the service. We reviewed this during our inspection and found 15 active risks. Senior staff demonstrated a clear understanding of the risks identified in the risk register and clinical staff worked to reduce risks. For example, one risk concerned the lack of cardiac monitoring equipment in the two patient bays in ED used for patients with infectious conditions. To mitigate the associated risks staff cared for such patients in a bay in the main ED and used advanced cleaning and disinfection to reduce the risk of cross-infection. We looked at the minutes for three governance meetings that took place in November 2018 and December 2018 and saw the acute medicine team reviewed and updated the risk register in line with changes to trust policies and developments.

Appropriate governance and risk management processes were not in place to manage patient and staff safety for those brought to the ED by police. For example, staff said it was a regular occurrence for police to drop off patients with mental health needs and leave them in the department without a handover. During our inspection staff struggled to provide safe care for a patient brought to the department by police who had assaulted four members of the ED team on the previous day. Staff were not equipped or resourced to care for the patient and to protect themselves from harm and governance and strategic partnership processes were not in place with the police. We saw this resulted in lengthy discussions between various teams during the inspection and staff said there was no governance process in place to support them. This meant staff on duty were taken away from providing care to debate areas of accountability with the attending police officers.

Nurses and paramedics who regularly delivered patients to the ED told us the lack of privacy and confidentiality for handovers in the corridors presented a risk. There were no areas for private handovers and staff said this meant there was a persistent risk of breaching patient confidentiality.

Staff in the ACU and the acute medical unit (AMU) said they felt pressured to take patients they did not feel could be safely cared for there. For example, one member of staff said, "The criteria for accepting patients here is constantly stretched and challenged and we have little say when we think a patient's needs are outside of what we can provide."

Consultants and associate directors of nursing reviewed staffing across urgent and acute medicine every morning and shared this information as part of a site-wide

escalation report. This was shared with all clinical and support services, such as pharmacy, to help coordinate services without interruption during times of short staffing.

Staff who delivered care to patients in corridors due to capacity limitations were unsure of trust standard operating procedures around corridor care. The local ambulance trust provided a hospital ambulance liaison officer (HALO) during peak times but we were unable to establish whether effective governance arrangements were in place for this service.

We spoke with nine acute doctors at various grades in the ACU and AMU about delays in treatment and the use of the area for inpatient care. Each individual described a lack of communication, gaps in clinical pathways and inappropriate referrals from GPs as significant challenges. Acute medical physicians and surgeons provided care but said turnover was high and four acute physicians had left in the previous 12 months. They said they were unaware of a trust-led escalation plan in place to provide support when patients were accommodated overnight.

Staff in the EDRU worked to a winter outliers management plan as a strategy to maintain performance and quality of care.

We found inconsistent standards of information management that risked breaches of confidentiality in the emergency department review unit (EDRU), the ACU and AMU. In the AMU we saw staff routinely left mobile computers on wheels (COWs) unattended with patient records on display. Although the computer system automatically logged out the member of staff if they did not use it after a period of time, there was a risk that unauthorised persons could access private information. Paper records were stored in lockable trollies. All five trollies we checked across the three units were unlocked and staff did not lock them when leaving the area. In EDRU a notes trolley was left with the lid open and notes readily accessible when staff were not in the area. We raised this as an issue with the trust during our inspection of medical care in May 2018 and they had not addressed it.

The trust worked actively with the local ambulance provider and ED staff were working alongside senior paramedics on a project to establish effective methods of admission avoidance. This involved scrutiny of corridor-based care and analysis of existing triage and admission avoidance systems to identify areas for exploitation and development.

ED staff were concerned that corridor care had become normalised and most of the staff we spoke with said they felt there was little clear drive from the trust to find alternatives. One senior member of the team said they had used corridor care every day for over 12 months and that the situation was not only a result of winter pressures.

Culture within the service

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Although the trust had improved working culture and relationships in the previous year, there were areas of further improvement needed.

All the ED staff we spoke with said they liked working in the department and felt well supported and looked after. Staff in the ACU and AMU said they were feeling demoralised from months of persistent pressure and working beyond capacity but said support from the senior nurses and matron was “excellent.”

At our last inspection in May 2018 we found a range of problems with the working culture and staff wellbeing, including reports of bullying and harassment. At this inspection we found a greatly improved working atmosphere and peer support culture amongst staff. A senior nurse said the divisional leadership team had, “…put a lot of effort into addressing bullying and harassment and the feeling of being undervalued felt by a lot of staff.” The trust had refurbished the staff room to provide an atmosphere more conducive to rest and provided a locker for each member of staff. Staff said the developments had improved morale and they felt more positive about their work as a result. Staff felt similarly in the AMU and said they felt the trust had worked hard to improve values and behaviours amongst all grades of staff. Staff were aware of the results of the latest staff survey, which had identified a need for further work in communication and engagement. Teams had started to address this, such as with the introduction of a regular newsletter for the ACU and AMU team and the implementation of a hospital-wide staff wellbeing team.

Urgent and emergency services

Although overall staff felt happier and more positive about working for the trust, staff we spoke with in EDRU felt this did not apply to them. They described persistent challenging working conditions and a lack of communication with the senior team. One member of staff said, “This is the forgotten ward. We do personal care, clinical care, the food and all of the meetings with relatives [of patients]. We speak but no-one listens, it feels like we’re completely by ourselves.” During our inspection we observed staff in EDRU field a number of concerns from relatives including one relative who wanted to complain about how dirty a patient room was and another who said they had not received an update on their relative’s care all day. Nurses struggled to answer these concerns. The manner of staff towards patients in the unit reflected the pressure they described working under. For example, a relative asked a nurse at the nurses station if a patient would be staying the night as they needed to go home and bring them pyjamas. The nurse was off-hand and replied, “I don’t know I haven’t started my shift yet”, before walking away. It took the relative a further 20 minutes and intervention from the ED lead nurse before they obtained an answer. When a relative approached a member of staff and said their family member’s room was dirty they shrugged their shoulders and said, “Well it should be clean, if it’s not someone will clean it tomorrow.”

The establishment of an education facilitator nurse had substantially increased opportunities for staff development and access to training. This included more staff accessing plaster training and the creation of an education pod with three computers to provide staff with access to trust mandatory online training. Combined with improved, more consistent staffing levels this contributed to an improved working culture in which staff had the opportunity to thrive. For example, a series of breakfast training sessions provided staff with the opportunity to engage with external trainers and specialists at the start of their shift to share learning experiences.

Staff in the ACU and AMU said mixed-sex breaches were difficult to avoid when the unit remained open for escalation purposes overnight. As staffing and inpatient care was not planned on a 24-hour model, staff noted difficulties in rearranging patient accommodation overnight to prevent a breach of this national standard.

Outstanding practice and areas for improvement

Outstanding practice

- The responsiveness of the lead nurse in ED to surge situations resulted in a rapid reduction of triage delays in the department. For example, by redeploying existing staff they reduced the triage time from two hours to 17 minutes within a two-hour period.
- Staff were proactive in identifying opportunities for improved practice for patients with complex needs, including the use of multidisciplinary social care assessment pathways.

Areas for improvement

Action the hospital MUST take to improve

- Improve performance in the national 15-minute triage recommendation.
- Ensure adequate risk controls are in place for patients who wait extended periods for triage.
- Ensure triage processes meet national best practice guidance.
- Improve the effectiveness of internal professional standards for patients who need a specialist review.
- Improve specialist review times and reduce delays in decision to admit times.
- Improve standards of privacy and dignity for patients cared for in ED corridors and in the EDRU.
- Ensure fire safety controls and standards are fit for purpose in the ED, ACU and AMU.
- Ensure staff have adequate training and confidence in non-medical emergency procedures, including in evacuation plans.
- Ensure patient's records are always stored securely and restrict access to electronic records to authorised staff.
- Staff in the paediatrics-dedicated ED must ensure that the audio-visual security system is routinely used.

Action the hospital SHOULD take to improve

- Improve governance processes and governance oversight of the streaming process to improve safety and reduce risk at the front end of the ED.
- Ensure the triage process is in line with national best practice guidance and provides sufficient oversight of the patients' immediate needs and risks.
- Ensure there are enough suitably qualified doctors available in the ED overnight to meet patient need.
- Ensure the availability of paediatric-trained nurses in the ED complies with RCPCH recommended staffing levels.
- Ensure staff in EDRU have the competencies and ability to communicate appropriately with the relatives of patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care was not always person-centred and did not always meet individual needs. Staff did not always make reasonable adjustments to the service to meet individual needs: • There was a lack of privacy and dignity for patients being cared for in the emergency department (ED) corridors. Patients were accommodated in these areas for extended periods of time and staff carried out intimate examinations without access to privacy screens. • Patients spent extended periods of time on trollies in areas with reduced privacy. For example, none of the corridors used to accommodate patients had restricted access and were used by other patients, staff walking through the area and members of the pubic.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always delivered safely: • Patients were cared for in corridors during times of high demand. Although a qualified nurse and care support workers were assigned to care for these patients, the environment did not ensure they could deliver safe care. For example, patients did not have emergency call bells.

This section is primarily information for the provider

Requirement notices

- All of the doctors we spoke with in ED, representing a broad cross-section of grades and experience, said they felt care delivered in the corridors was inherently unsafe.
- Doctors told us they felt the streaming process in place was unsafe and presented an unacceptable level of risk to patients.
- There were significant risks in the triage process. The Royal College of Emergency Medicine recommends triage be undertaken within 15 minutes of a patient arriving in ED. During our inspection, triage was delayed by up to two hours and five minutes due to demand on the service. In one instance a patient deteriorated rapidly whilst awaiting triage and was transferred as an emergency to the resuscitation unit. Improvements in time to triage formed part of an action plan in August 2018, which the trust identified as an area for improvement by September 2018. This was not fully embedded at the time of our inspection.
- The triage process did not adhere to national best practice standards and was instead a brief initial assessment.
- There were significant delays in doctor-led clinical reviews in all areas we inspected. At one stage in our inspection there was a delay to be seen by a doctor in ED of three hours and in the ambulatory care unit of six hours and 15 minutes.
- ED doctors did not have the authority to make a decision to admit (DTA) to medical or surgical specialties. Internal professional standards were in place but varied between specialties, which led to lengthy delays to patient care. Delays in review by general medicine were substantial, with some patients waiting over 14 hours in the ED. In August 2018 the trust implemented an action plan to improve patient flow through the inpatient wards from ED by March 2019 but we saw very limited evidence this was in place.
- Nurses in the EDRU did not have immediate access to doctors for patient review or support. At one stage of our inspection a nurse paged for a doctor twice in a 40-minute period to carry out an urgent clinical review with no response. Nurses said this was a common situation and overnight the situation was, “usually far worse”.

This section is primarily information for the provider

Requirement notices

- In August 2018 the trust implemented an action plan, due for completion by March 2019, to ensure there was always a clinical member of staff with advanced paediatric life support available in the ED. This was not in place at the time of our inspection.
- In August 2018 the trust implemented an action plan that required staff to consistently complete patient safety checklists and patient risk assessments. This had not been fully implemented at the time of our inspection and patients cared for in corridors did not have timely, consistent risk assessments.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises were not always secure, suitable for the purpose for which they were being used and properly used: • The paediatric ED was equipped with technology to control access, including a videolink to enable staff to remotely unlock the entry door on verification of a person's identity. However, the system was disabled during our inspection and access to the area was uncontrolled. In August 2018 the trust implemented an action plan to secure the paediatric ED immediately and ensure consistent use of the entry security system. Staff were unaware of the action plan requirement to secure and monitor the area. • In August 2018 the trust implemented an action plan that required our previous concerns about poor fire safety, found from March 2018 to May 2018, to be acted on. This included assurance that fire exits would be unobstructed and fully accessible. During our inspection we found unacceptable standards of fire safety including obstructed escape routes, damaged and obstructed fire exits, fire doors forced to stay open and very limited understanding of evacuation processes amongst staff.

This section is primarily information for the provider

Requirement notices

- In August 2018 the trust outlined a plan to ensure storage in the ED was appropriate and safe, with a due completion date of November 2018. During our inspection we found it was common practice to store large quantities of consumables and equipment in corridors, offices, clinical areas and in fire escape routes. For example, one clinical room in the emergency department review unit (EDRU) was used as a storeroom following the conversion of a dedicated storeroom into an office.
- We found staff in ED and the AMU did not routinely secure storage areas for cleaning chemicals despite notices on storage area doors stating this as a local safety requirement.