George Eliot Hospital NHS Trust

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Inspection report

Eliot Way
Nuneaton
CV10 7RF
Tel: 02476351351
www.geh.nhs.uk

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Urgent and emergency services

Good  

We carried out this unannounced focused inspection of the urgent and emergency care core service. We checked the quality of the services in response to a warning notice we issued following our inspection of the services in December 2019. In the warning notice, we set out areas where improvement was needed including medical staffing, access and flow, culture and governance. This focused inspection was to see if improvements had been made within the service.

During this inspection we inspected the urgent and emergency core service using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have re-rated some key questions based on the findings from our inspection. Overall, we rated safe, responsive and well-led as good. We did not rate the effective or caring domains. This means we rated urgent and emergency care as good overall.

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- The service planned care to meet the needs of local people and took account of patients' individual needs. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However,

- Not all staff had completed training including life support and safeguarding.
- Patients were receiving the right care but the documentation was not always up to date.
- Whilst the hospital were performing better than the England average for meeting national waiting time targets, they were still not always seeing patients within a timely manner.
- Managers did not always ensure that there was an action plan associated with an audit when they fell below compliance.

Is the service safe?

Good  

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and mostly made sure everyone completed it.

Urgent and emergency services

Nursing staff received and kept up-to-date with their mandatory training. This training was comprehensive and met the needs of the patients and staff. Overall training completion figures for the emergency department (ED) and children's assessment unit (CAU) were 90% and 94% respectively; they were both above the trust target of 85%. Training data was discussed in the monthly governance meeting. The practice educator displayed the mandatory training completion data in the staff room.

Managers monitored mandatory training and alerted staff when they needed to update their training. Each band 7 had a team of staff and encouraged them to complete any outstanding modules. The staff were responsible for updating and booking onto their training themselves. Staff were given time within work hours to complete their e-learning training. We were told that at times, staff did not attend training if the ED was very busy.

All staff had to be compliant with different levels of life support training depending on their banding or level. All staff had to complete basic life support (BLS); 95% had completed it. Band 5 staff nurses and above needed Immediate Life Support (ILS) and Paediatric Immediate Life Support (PILS) training; 54% of staff had completed ILS and 73% had completed PILS. In CAU, 100% had completed Level 2 adult BLS and level 3 PILS. The department also offered life support training to some of their long-term agency or bank staff to ensure they were fully equipped to work in the ED.

Medical staff did not always keep up-to-date with their mandatory training. Medical staff training showed an overall mandatory training compliance rate of 81%. The low compliance was on the department risk register. Medical staff training figures showed that for level 2 adult BLS they were 86% compliant, 80% compliant for level 2 Paediatric BLS, 100% compliant for level 4 paediatric advanced life support (ALS) and 92% compliant for level 4 adult ALS. We were told that if staff had a few modules outstanding, the clinical supervisor would arrange a meeting and support them to complete the training. A consultant told us that they had just met with a junior doctor and would have another meeting in a month to ensure modules had been completed. Following our inspection, we were told that the clinical director had emailed all medical staff individually to remind them of the planned trajectory to achieve compliance by the end of May 2023 and had already seen improvements since the inspection.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered the appropriate subjects including safeguarding, restraint, resuscitation, infection prevention and control and moving and handling.

A new mandatory training package had launched in April 2023 specifically on caring for patients with autism and learning disabilities. Staff could access support from specialist teams and nursing staff when needed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse and they knew how to apply it. However, not all staff had completed their safeguarding level 3 training.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff knew how to make safeguarding referrals and who to contact if they had concerns about patients.

The training compliance data for nurses and support staff showed that the overall mandatory training compliance was 96% for safeguarding adults' level 2 and 95% for safeguarding children level 2. The trust also required band 5 staff and above to complete safeguarding adults and children's level 3; ED nursing staff were 68% compliant, CAU were 64% compliant and the medical staff were 59.5%. The trust target was 85%. The managers were aware of the poor

compliance and told us that the training had moved from a 3-yearly course to annual and this meant that all staff had to complete the course. They also told us that the department had been overwhelmed with patients throughout the winter and this had resulted in courses being cancelled. This was on the service's risk register. Mitigations were in place including, the safeguarding team attending the ward daily and a 'safeguarding Thursday' between 9 and 10am where they were available in ED to discuss any safeguarding issues the staff had. There was a monthly focussed safeguarding meeting attended by the multidisciplinary team. They had recently launched a video of the training to make it more accessible rather than only offering it face to face. Managers said that there was an active safeguarding reporting culture and had not had any incidents where safeguarding was not reported correctly.

Safeguarding policies and pathways were in-date and were accessible to staff via the trust's intranet. These included clear guidance on completing the multiagency referral form, female genital mutilation and non-accidental injuries for children and adults. Staff had access to the trust safeguarding lead for advice.

There was patient information on recognising signs of specific abuse on display within the department.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Children identified as being at risk while in the ED were referred to the trust safeguarding team and to the local authority appropriately. The safeguarding lead attended the department daily and offered support to the staff with dealing with paediatric safeguarding referrals. There was a safeguarding link nurse within each area.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were aware of the Mental Capacity Act and the holding powers that doctors, and nurses had. Staff got the advice from their mental health colleagues as required; they were available 24 hours a day, 7 days a week. Staff reported that they were very supportive and easy to access. The ED had recently commissioned the NHS England Core 24 standard for mental health which ensured there was a provision of liaison mental health services. There was a pathway to follow for paediatric patients who presented with mental health conditions. The trust reported that whilst the mental health liaison team were responsive, they often struggled to get a bed if a child required admission to a mental health unit; some children had waited 2 days for a bed.

Cleanliness, infection control and hygiene

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

All areas within the ED were visibly clean and had suitable furnishings which were mostly well maintained. Whilst furnishings, such as chairs and flooring were wipeable and easy to clean, we saw some chairs which were ripped and needed replacing. Staff told us that they cleaned equipment after patient contact but they did not always label it to show when it was last cleaned. Following the inspection, we were told that 'I am clean' stickers had been ordered, the matron had reinforced the importance of their usage within the safety huddles and via a closed encrypted social media application group. We were told this would be monitored by the matron and senior nurse on a weekly basis. There was enough personal protective equipment (PPE) available for staff to equip themselves for the different levels of protection. Staff followed infection control principles including the use of PPE. Hand hygiene sinks, hand gel and PPE were available throughout the department. Staff were bare below elbows for effective handwashing and always wore surgical masks. However, we saw a few staff who did not wear their surgical masks properly and had their noses exposed. Managers audited compliance to the uniform policy in both ED and CAU which was consistently above 95% for the last 3 months.

Managers audited staff compliance with infection control practices including hand hygiene and cleaning. Hand hygiene audit results were 100% for March and April 2023 and 87.8% for May 2023. Whilst there was no action plan associated

with the audit, we saw that compliance was reported and discussed within the governance meetings. There was also a monthly infection prevention report where audits were discussed, and actions were taken to make improvements. For example, in February 2023 report, it was noted that level 2 Infection prevention and control (IPC) training was below trust standard; it was then reported on weekly and was showing an increase. Staff were aware of the audit results. Managers said that poor compliance was addressed in handovers and their secure group social media messaging application. Audit results showed staff were following infection prevention and control guidance and that the ED environment was kept clean and tidy.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audits were consistently above 96%. There were 3 regular domestic staff who cleaned the ED to a high standard and took pride in their work; 1 told us that they had never failed their cleaning audits and there hadn't been an infection outbreak in the department since they started 7 years ago.

Staff received training about Infection, Prevention and Control (IPC) and hand hygiene training during their initial induction and annual mandatory training. Training data showed that 95% of nursing staff, 86% of medical staff and 100% of CAU staff had completed IPC level 2 training.

The staff could get further IPC information from the Infection Control Nurses; they attended the department daily. We were told they were very accessible and approachable.

Side rooms were available when isolation was required, and staff told us how they would manage the risks associated with transmittable infections. The information staff told us was in line with best practice.

Data showed that there had been no infection control cases reported in the last 3 months. This included E-coli, Methicillin-Resistant Staphylococcus Aureus (MRSA) and Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia.

Once patients were admitted to the department, staff took appropriate actions to prevent the transmission of COVID-19 and other infections. Suspected COVID-19 patients that were symptomatic had a rapid test on arrival. There were 5 cubicles with doors for patients who presented with COVID-19 symptoms or had tested positive for COVID-19 to ensure they were isolating from other patients.

The sluice within majors had been relocated in November 2022 and it was now smaller. This meant there was a risk of contamination as staff were unable to adequately clean commodes, dispose of infectious waste or store items. This was on the risk register and discussed within the IPC report. The managers were putting in a capital bid to relocate the sluice to reduce the risks. There had been no infection outbreaks within the department.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Most areas in the department were suitable for their purpose and mainly clutter free. The service had 33 beds and 6 fit to sit recliner chairs across majors; this included 3 resuscitation beds. There were 3 paediatric cubicles, 3 seated cubicles and 1 resuscitation bed in the CAU. The hospital did not have any inpatient paediatric beds. ED were also able to safely have up to 7 patients in the corridor; we saw one patient was moved into the corridor whilst we were in the department prior to their discharge home. Managers told us that if the department became overwhelmed, they cared for patients on the corridor. In April 2023, 117 patients were

cared for in the corridor; this is an average of 3.9 per day. There was a nurse who was assigned to look after the corridor patients throughout each shift if this happened. Portable call bells and dignity screens were in place on the corridor. The managers said that the call bells were portable so that it did not become expected practice to care for patients in the corridor; there was a lack of space, and it was not a suitable environment to be for long periods of time. There was a standard operating procedure which detailed a criteria for patients who could and could not be cared for on the corridor; there was escalation to the executive team and boarding on wards before corridor care was initiated.

The service had a Rapid Assessment and Treatment Triage (RATT) area and a 'Fit to Sit' area. The RATT had 8 trolley spaces and 2 of these had central monitoring. This area was used to assess and triage patients who were either brought in by ambulance or came through triage. These patients were then moved to an appropriate area within the department. A detailed analysis of the flow through the ED showed that they needed 7 beds in RATT per hour to meet the demand of the patients. The 'Fit to Sit' was an ambulatory area with 6 recliner chairs. This had limited space and was used for patients waiting for a bed in majors.

There was a Clinical Decisions Unit which was previously being used as a respiratory area for patients who had symptoms for COVID-19. There were 6 beds across 2 bays including 5 side rooms. There was also a further large side room which was used if there was a patient who had a highly infectious disease as it had a separate bathroom and plenty of room for any necessary equipment.

The resuscitation area had 3 beds. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the ED. Daily safety checks of specialist equipment had been carried out.

Patients who attended with suspected minor injuries were seen in the urgent treatment centre (UTC) which was located next to the waiting room. There were 5 rooms, and these were staffed with a GP and 2 emergency care practitioners (ENP). This was open 8am to 8pm; they were looking at extending the hours until 10pm. The ENPs and GPs looked at the patients within the waiting room and the triage information and selected patients who were suitable. They also saw paediatric patients who were appropriate. They saw approximately 30% of the patients who attended ED. The service had recognised that there was an increase in footfall into the UTC on bank holidays and had arranged for 2 further GPs to support on these days from 9am to 5pm.

Walk-in patients were initially seen at a streaming desk which was located by the entrance; this was staffed by a triage trained nurse. The nurse directed them to either the UTC or triage for majors; they were then booked in at the main reception area. Patients could not go into the department without being seen by the streaming nurse; if the department was busy, there could be a few patients waiting outside until they were seen. The trust had installed 2 heated shelters for patients to wait in if the department was overwhelmed. Any patients who required urgent assistance would be taken to majors immediately by the streaming nurse. After booking in, patients saw the triage nurse and were asked more details about their condition. They were graded according to the severity of their presenting complaint. The waiting room had visibility from the reception team. Whilst we were there a patient collapsed in the waiting room and the reception staff alerted the ED team. This was handled quickly and well. However, there was no emergency buzzer within the reception, this meant that the receptionist had to leave to find someone to help.

There was subtle calm music being played in the waiting room which also had voice commands which told the patients an accurate waiting time to be seen. Alongside this there was a screen which displayed the waiting time; this was installed following feedback from a patient who was hard of hearing and found it difficult to hear the voice commands.

A locked CAU was located next to the main ED but operated as an independent unit, thus separating the children's and adult's emergency care pathways as recommended by national standards. The CAU consisted of 6 cubicles,1 resus room

and 1 triage room; 3 cubicles contained trolleys and 3 contained chairs for those children identified as being lower acuity. The service was supported by qualified paediatric nurses, a consultant paediatrician and a junior doctor Monday to Friday 8am to 10pm. A consultant paediatrician remained on site outside of these hours to support maternity and special baby care unit, and so were able to provide advice and support to the emergency team out of hours. The waiting area within CAU was very small and the service recognised this was something they needed to improve and was on their risk register; the managers were applying to secure some funding to build a first floor above the current ED to increase the footprint of the department.

Patients could reach call bells and staff responded quickly when called. There was enough suitable equipment in the ED to help staff safely care for patients. However, we found that this had not all been electrical safety tested. Following our inspection, the equipment was all checked, and electrical testing occurred for the equipment that was out of date. They have also changed their process to ensure that compliance was maintained, and escalation occurred when out of date equipment was found.

Clinical waste was disposed of safely using separate designated waste bins for general and clinical waste and sharps buckets for sharp instruments were available throughout the department.

The service had created the 'Bluebell Room' which was as non-clinical as possible for people who were end of life or suffering from a miscarriage. This meant that they were given the privacy they needed in a difficult time. There was a small relative's room which was linked to this. The room had a landscape mural and feedback was that was calming and warm. The staff were proud of this room and that it enabled them to give better care to the patients.

The department had received funding to upgrade the mental health assessment areas. They had a task and finish group and involved the mental health trust, dementia team and used evidence-based information. The project consisted of creating mental health packs, upgrading the current room to include access to a TV and reduce ligature points, install wall murals and circadian rhythm lighting. There were 2 cubicles which were being upgraded to make them suitable for mental health assessments and 5 cubicles are also being upgraded to enhance the area for dementia patients. They had recently upgraded majors to have 5 rooms with glass doors to manage infectious patients, patients who required reverse barrier nursing and to provide privacy for sensitive conversations.

The department had changed all its signs following feedback from patients. They had created simple process maps which highlighted the expected pathway and expected time frames. The signs were changed to purple and white to make them easier to read; this was following feedback from a visually impaired patient and through speaking to the dementia team.

There was a high-risk room which was anti-ligature and had weighted furniture however, the sofa and chairs were ripped; we were told that replacement furniture had been ordered. There was a panic button panel which was installed around the whole room down low which would trigger assistance. There were two exits from the room. All staff also had pinpoint alarms which automatically triggered security; this was implemented on the back of an aggressive incident.

There was a same day emergency care unit within the medicine service. This could take up to 20 patients a day from ED. Plans were in place to increase operating hours of the unit.

Assessing and responding to patient risk

Staff mostly completed risk assessments for each patient swiftly. They removed or minimised risks but did not always update patient's risk assessments in line with national guidance or trust policy. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

Staff completed risk assessments for each patient on arrival, using a recognised tool, in a timely way. Patients who arrived by ambulance were handed over to the RATT unit mostly within 30 minutes; they remained in the care of the ambulance service until they were handed over to the ED staff. The hospital had clinical responsibility for these patients. The March 2023 board report showed that between April 2022 and January 2023, 11.2% of ambulances were taking over 15 minutes to handover; this was better than the national average of 24.4%. Over the last 12 months, 5% of ambulances were taking over 60 minutes to handover and this was better than the national average of 14%. These patients were triaged by a RATT nurse who then rated their order of clinical emergency using a nationally recognised RAG rating triage tool. This determined how quickly they needed to be seen and how often their observations needed to be completed. For patients who were rated as red, they were brought into the department as soon as possible to prevent deterioration. The RATT nurse had received further training to complete this role. If there was a delay for a patient to be admitted to RATT, medical staff assessed the patients and started any treatment where possible.

All walk in patients were seen by a triage nurse who assessed them using the Manchester Triage Score (MTS). This determined the patient's acuity level and RAG rated them on importance of being seen. They also completed an initial assessment tool (IAT) which determined the patient pathway needed. There were 29 pathways such as fractured neck of femur and sepsis. The pathways set out what was needed for the patients. This was brought in after the previous inspection and was to make the process more streamlined for nurses. Walk-in patients were not always assessed or given treatment in a timely manner. Standards set by the Royal College of Emergency Medicine (RCEM) state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. Figures had improved from 32.7% in December 2022 to 50.4% in February 2023; the department had been consistently above the England average between September 2022 and January 2023. During our inspection, we looked at 10 records and saw that 6 out of the 10 patients were seen within 15 minutes of arrival. Senior staff reduced the risks associated with delays to triage by allocating experienced nurses to work in triage. They also increased the number of nurses in triage if they noticed there was an increasing delay; this happened on the day of our inspection, a second triage nurse was allocated, and this brought the triage waiting time down. All nurses who worked in triage had completed training. Skilled nurses ensured that the sickest patients were identified, or those most at risk of rapid deterioration, as soon as possible. If a patient came in with chest pain, they were given a sticker with a heart on to present at reception and this was attached to their booking notes; this meant that the receptionists and clinicians would recognise the need for urgent treatment.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Adult patients were assessed using the National Early Warning Score (NEWS2) as recommended in guidance from the National Institute for Health and Care Excellence, Clinical Guidance (CG) 50: 'Acutely ill adults in hospital: recognising and responding to deterioration' (2020). The NEWS2 determined the degree of illness and was based on the patient's vital signs, including respiratory rate, oxygen saturation level, blood pressure and heart rate. The score was highlighted on the initial assessment as an early warning score which helped to identify patients most at risk of deterioration or sepsis. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs, and action is required quickly. Training figures showed that sepsis training was at 95% compliance. There was a specific form to assess sepsis within the paperwork. We found that the staff had acted upon the patients needs and given the treatment required, but the documentation was not always completed. The trust completed weekly documentation audits which looked at the completion of the sepsis paperwork. Between 18 January and 26 March 2023, the service audited 120 sets of notes. The compliance improved over the months for the completion of the sepsis paperwork. In January 2023 compliance was 60%, this had improved to 87% in March 2023. We saw that nurses and medical staff were aware of recognising sepsis and we saw no delays in treatment for suspected sepsis patients during our inspection. The medical team completed an audit of 58 patients between January 2021 and December 2022 who were diagnosed and treated for sepsis. They audited compliance to the sepsis 6; this is a set of 6 tasks which need to be instituted within 1 hour of suspected sepsis. There was good compliance with completing blood gases, measuring lactate and giving oxygen. However, improvements needed to be made in giving antibiotics within the first hour and

doing blood cultures. The findings also showed that 0% of patients had urine output measurement commenced or documented. The outcome of this audit was presented to the medical staff. The trust told us that since the inspection, the practice development nurse would focus on improving sepsis compliance and deliver sepsis training and education. They would continue to audit sepsis and do spot checks of the paperwork to increase compliance.

Patient observations were recorded on paper and electronically. Patients wore a barcode on their wrist which uploaded the score to the computer system. The patients most up-to-date NEWS2 score was displayed on the large screen in majors; this meant that the lead consultant and nurse in charge could see an increasing NEWS2 and recognise a deteriorating patient. Arrows indicated if the score had increased or decreased since the last observation set. The NEWS2 was initially done in triage and helped to determine the location for the patient within the department. For example, a patient with a NEWS2 above 5 would need to be in majors or potentially resuscitation depending on other symptoms. We saw that NEWS2 were completed regularly and escalated appropriately when they were scoring high. Anyone with a score of 5 was escalated to the outreach team. The service did not audit NEWS2 completion.

All paediatric patients were triaged on arrival to the unit. The service audited their triage documentation; in March 2023 they were 62% compliant and this increased to 87% in April 2023. Patients had their clinical observations taken at triage and documented on the Manchester triage score (MTS). As per the MTS, if appropriate, recording of the baseline observations using a Paediatric Early Warning Score (PEWS) would be conducted depending on the clinical presentation. Staff within the CAU used PEWS to assess the children and determine their acuity. However, they were unclear of when to use this. We found that it was sporadically in use and there was no escalation for it if a higher PEWS was found and there was no protocol for its use. This meant that there was a risk that a deteriorating patient was not recognised. Following our inspection, a meeting had been arranged to develop and agree a Paediatric Observation and Monitoring Policy. The paediatric practice development nurse will also complete PEWS training for staff working within CAU.

Staff did not always complete risk assessments for each patient on admission, using a recognised tool, and review this regularly. We looked at 10 sets of records and found that some risk assessments were not completed or re-reviewed following long stays in the department. For example, an initial body map was completed on arrival which looked at the patient's skin and any broken areas, but if a patient stayed longer than 6 hours, a subsequent Waterlow assessment was not completed. This meant there was a risk that patients could develop a pressure sore within the department due to a lack of assessment of their skin. We did see that for patients who stayed longer, hospital beds were requested instead of trolleys; this was to reduce the risk of pressure area damage. The team audited the documentation monthly and found compliance to be 54% in January, 74% in February and 76% in March 2023. The service had an hourly safety checklist for the nurses to complete. Out of the 10 notes that we looked at 7 of them had not had their checklist completed hourly; 1 patient had been in the department for 17 hours and it had only been completed for 4 of the hours. This was audited by the trust monthly and completion of the checklist was poor but gradually improving. In January 2023 it was 62%, February 2023 it was 77% and March 2023 it was 82%. Following our inspection, we were told that the management team were working with the nursing team to empower them to improve compliance and would assess this with spot checks and monthly audits.

Risk assessments to assess a patient's risk of developing blood clots whilst in hospital were not always completed in line with national guidance or trust policy. The trust's venous thrombo-embolism (VTE) or blood clots standard is for a risk assessment to be completed within 6 hours from arrival of the patient in ED. Data showed that 140 out of 481 patients between 1 May and 12 May 2023 had a VTE assessment completed within 6 hours of arrival in ED. However, we were told that the policy for ED was to complete a VTE assessment for lower limb immobilisation only. We were told that 463 out of the 481 patients who moved from ED to inpatient beds had a VTE assessment completed within 24 hours of their arrival in ED; this was done by the speciality teams on the wards. The doctors told us that it was not their responsibility, and it was the responsibility of the admitting clinician; patients were waiting for long periods of time in the department

without an assessment being completed. Following our inspection, the trust stated that they had reiterated the standard to all emergency medical staff and compliance would be monitored and added to the governance meeting agenda.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had good support from the mental health team who advised and assisted staff with mental health issues. They were creating mental health packs for de-escalation of patients. They had recently changed their mental health triage assessment paperwork as had found that it wasn't being completed as it was too long. They had changed it to 1 page including a risk assessment and had found an increase in compliance. The RCEM had also used it within their library of best practice. We spoke to a patient who had been admitted with mental health concerns and they told us that the staff were sensitive to their mental health needs. In April 2023, there were 76 patients referred to the mental health team and 43 patients who required admission; on average they waited 3 hours 14 minutes to be admitted. Staff had access to a psychiatric liaison service 7 days a week from 8am to 6pm and 8am to 4pm at the weekends. Out of hours the staff would contact the crisis team. Both teams were provided from the local NHS community trust.

The managers worked closely with the police service to enhance the process for the patients they brought into the ED and to reduce the risk of the patients absconding; they had locked all doors and applied codes to ensure patients could not abscond.

We saw that the guidelines and pathways for illnesses, such as diabetic ketoacidosis and sepsis, were available, appropriate and in use. There were protocols in use for emergency situations, such as trauma, cardiac arrest and major haemorrhage which would be attended by specialist teams. Cardiac arrests were managed in the ED within the day and overnight specialist teams were alerted to attend.

During our previous inspection, we found that stroke pathways were not being followed. Since then, there has been a reconfiguration of the service and a new pathway had been implemented. Patients who have suffered a stroke were no longer admitted to the trust; they were transferred to a neighbouring trust which had an equipped stroke unit. They were transferred back to the hospital to a rehabilitation unit once they were stable.

They had recently implemented a hand fracture pathway following a complaint where a patient's fracture was not well managed; they have since brought in a new pathway which ensured all hand fractures had oversight from trauma and orthopaedics specialist doctors.

There was a clear pathway for paediatric patients. There was a transfer policy in place to transfer to a paediatric site depending on the need of the child. The team felt that at night there was more risk as parents brought children into the department to avoid queues at other paediatric sites; there were no consultants in the department, only on call, and no paediatric beds.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. The staff had a few opportunities throughout the day to share information with the senior team. There was a morning and evening handover and then a huddle at 10am and 2pm. We attended a 2pm huddle. This was led by the nurse and consultant in charge. Each patient within the department was discussed and a plan was put into place. This meant that the nurse and consultant in charge had a good overview of the risks within the department; this had improved since our previous inspection where we had felt

that the senior clinician did not have this oversight. The nurse in charge and consultant in charge had a joint desk in the middle of the ED and staff knew where to find them for advice. At the end of each shift, the nurse in charge (NIC) completed a coordinator handover which included risks within the department, ambulance delays, transfers out of ED, long waits, and any incidents that had occurred to the next NIC.

The leaders assessed the department every 4 hours using the NHS England Operational Pressures Escalation Levels (OPEL) framework. It generated different responses depending on the overall score. It had 4 different levels with level 4 being the highest pressure which meant they were unable to deliver comprehensive care. At the time of the inspection, the department was OPEL 3.

There were progress chasers within the department to help with the flow of patients. They chased results, informed doctors when they were back to avoid delays, they observed how long patients had been waiting and they worked closely with the bed management team.

The department had local safety standards for invasive procedures for several procedures which were conducted in ED. These standardised the process and ensured that procedures were done safely. These included a chest drain insertion, lumbar puncture, and fascial iliac block.

We were told that at present there was no practice emergency scenarios run from the ED, but the practice clinical manager planned to restart these in May 2023 on a weekly basis.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe, managers regularly reviewed staffing levels and skill mix**.** Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Nurse staffing in the ED had been established as 18 nurses and 4 healthcare assistants per day shift and 17 nurses and 3 healthcare assistants at night. The number of nurses and healthcare assistants matched the planned numbers on the day we inspected. There was a matron who was in charge and very visible within the department. The staff mostly worked long days but had recognised that there was an increase in activity between 3pm to 9pm. The managers had introduced a twilight shift with a flexible start time to suit the staff anytime between 12pm and 4:30pm. They told us that complaints had reduced since introducing an extra member of staff to this twilight shift.

The service had high vacancy rates; there was a 24% vacancy rate which was the equivalent to 14.09 whole time equivalent nurses and health care support workers. This was on the department risk register and there was an action log associated with this. It included measures to increase staffing such as a recruitment event at the end of April 2023, block booking of agency and bank staff, videos to promote the department, and scope out the possibility of recruiting paramedics into the department. There were also 5 nursing associates who were due to graduate into the band 5 positions over the summer who would reduce the vacancies significantly. They had fully recruited into band 7 and overrecruited band 6 positions; their focus was on the band 5 workforce. The staffing gaps were covered by regular agency and bank staff. New nurses attended a trust induction and a local induction and training. Agency staff were regular staff who knew the department and were experienced ED nurses. New bank and agency staff underwent a local induction in the department. UTC had no vacancies at the time of inspection and CAU had 2 vacancies: a band 5 nurse and a band 6 nurse.

The ED had a turnover of 17% between January and March 2023; the trust target was 13.5%. They found that it was a challenge to keep staff in the department due to the high intensity environment. They were developing a more comprehensive induction pack and were due to complete a skill gap analysis to ensure that the department was fully established in its staff's skills. CAU had a high turnover of staff at 38%. CAU told us that no staff were leaving at the time of the inspection.

The service had reducing sickness rates. The service had sickness rates of 7.64% in January 2023 which had decreased to 4.63% in March 2023; the trust target was 4%. The levels were higher in CAU between 8% and 12% from January to March 2023. We were told that there were varying reasons for sickness, and it was not work related.

The service had had high levels of agency nurses. Between January and March 2023, the service had an agency usage of around 29% and 16% of these shifts were unfilled. Managers requested staff familiar with the service; they were all long-term agency staff who knew the department. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. There were 11 consultants within the department. A consultant was in the ED 8am to 12am every day and weekends until 10pm. This met the RCEM recommendation of 16 hours consultant presence every day. This had improved following our last inspection where we found high vacancy rates and poor consultant cover. There was 1 consultant on an early shift, 2 on a twilight and 1 on call. There were also other consultants within the department who were an additional resource if required. An on-call consultant covered the out of hours period 7 days a week. The service had a good skill mix of medical staff on each shift and reviewed this regularly. They had recently adjusted the rota to have an additional middle grade medic for times where patients are more likely to breach the 4-hour wait. There was a GP service that ran from 8am to 8pm every day. This was either delivered by a GP or an ENP. They saw 30% of the patients who attended ED.

The service had varying vacancy rates for medical staff. At consultant level, there was 1 vacancy, and this was due to the consultant being promoted to Acting Chief Medical Officer. There was a 36.84% vacancy rate at middle grade level; this was equivalent to 4 doctors. There was a full rotation of junior doctors with fixed term contracts to support this.

The service had high turnover rates for medical staff. This had remained around 25% for January to March 2023; the trust target was 13.5%.

Sickness rates for medical staff were reducing. There was a decrease from 6.64% in September 2022 to 3.35% in March 2023; the trust target was 4%.

Managers could access locums when they needed additional medical staff. The service had high rates of bank and locum staff. Between January and March 2023, 36% of hours were filled by locum staff within the ED and 23% within CAU. We were told that they had 3 regular locum doctors who generally worked nights. Managers made sure locums had a full induction to the service before they started work.

We spoke to a registrar and a foundation year doctor who both confirmed that they had regular programmed time for teaching and training and had received induction when they started in the department. They were satisfied with the way the rotas were managed and they told us that they had access to senior staff when they needed advice, including out of hours. We were told that 8 of the 11 consultants were on the specialist register and 2 were awaiting registration; they were receiving support from the department for this.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed on paper charts. Staff completed medicines records accurately and kept them up-to-date. We looked at 10 medicine charts and they were all completed in line with national guidelines and all medicines were given when prescribed. Allergy statuses of patients were routinely recorded on all medicine records seen and a red wrist band was worn by patients to identify the medicine causing the allergy. This meant that allergies were highlighted, and medicines could be prescribed safely.

Medicines supply from pharmacy were available and staff knew the routes to obtain medicines out of hours if required. The medicines were stocked up twice a week by pharmacy. Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. The service completed an annual medicines storage audit; this was 85% for the clinical decision unit. This was completed for the other areas within the ED which showed that medicines were mostly stored well but there was no overall percentage and no associated action plan.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff checked patients medicine requirements on their prescription chart prior to administration. If a patient had an extended length of stay within the department, a pharmacist would complete a medicine review, however this routinely occurred when patients moved into inpatient areas.

Emergency medicines and equipment were available. All expiry dates checked were in date. There were tamper evident seals in place to ensure they were safe. Staff recorded weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency.

Medicines and controlled drugs (medicines requiring more control due to their potential for abuse) were stored securely. Checks were undertaken and recorded by 2 staff twice a day. Checks of CDs showed that they were within date and stock balances were accurate. There were 0 CD incidents between February to April 2023. Controlled drugs were audited by pharmacy; December 2022 audit was 90% compliant and February 2023 was 93%.

Medicine fridges were locked and secure with authorised staff access only. Records of medicine fridge temperatures were recorded daily and were mostly within a safe range for medicine storage. Fridge temperatures were taken but we found that when they were out of range, they were not always acted upon. For example, between 13 and 15 February 2023 the fridge temperature within the resuscitation room was between 9.2 and 9.6 degrees Celsius; normal fridge temperature range is 2 to 8 degrees Celsius. There was no documentation of action taken to ensure that the fridge returned to normal temperature and medicines were stored safely.

The department was in the process of introducing patient group directives (PGD's) with a standard operating procedure. This allowed nurses who were band 6 and above to administer specified medicines to a pre-defined group of patients, without them having to be prescribed. There were 11 medicines that were under a PGD included medicines for a low

blood glucose, basic pain relief and medicine to treat chest pain. They were in the process of obtaining all the signatures from the staff for the PGDs to be sent to pharmacy and put onto a register. We were told they would review in 3 months once they were in place. The managers were hoping that implementation of the PGD's would assist in bringing down the 4-hour performance as the nursing staff would be less reliant on the medical team for some medication.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines history was taken on admission to ED by the medical staff. This information was recorded into all the patients notes we reviewed.

Staff learned from safety alerts and incidents to improve practice. The medicines safety and optimisation committee presented at the monthly governance meeting. The service had recorded 88 medication incidents between 1 April 2022 and 31 March 2023; 81 were no harm, 6 were low harm and 1 was moderate harm. The incident which was moderate harm was identified as a theme across the urgent and emergency care directorate as well as the medicine directorate. A joint tabletop review was undertaken and an action plan was devised. The trust had an electronic system for recording incidents and staff we spoke to were able to identify its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported. We saw learning from the April 2023 governance meeting which reminded staff not to give patients who were addicted to certain medications, their own supply of controlled drugs alongside a supply to take home; this would be an oversupply.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff received feedback from investigations of incidents, both internal and external to the service. We noted a positive incident reporting culture and evidence of learning from incidents through our discussions with staff. For example, a patient was discharged with no fixed abode, they were then reported as a missing person and found 7 days later in an intensive care unit. The service had changed their process and did not discharge anyone with no fixed abode without speaking to social team and ensuring that the patient had an appointment with housing. We were also told about a patient who had burned themselves, it looked superficial, and they were discharged. They presented again and the burn was significant. The department had learned from this and had created a proforma for burns with tissue viability involvement and burns centre if required. They had invested in burns assessments packs as they found that no appropriate dressings were previously available.

The service had no never events in the department in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers following national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The service reported 2 serious incidents within the last 12 months. The service reported 536 incidents to the national reporting and learning system; the most common categories were unsafe or inappropriate environment, communication failure or lack of clinical or risk assessment.

Managers shared learning with their staff about incidents mostly through their communications meeting prior to their handover and via an encrypted social media application group. We also saw a copy of the ED incident report summary poster for March 2023. It emphasised that they operated a no blame culture and that they wanted to learn from incidents. The top themes for the month were administrative process, diagnostic processes, and pressure ulcers. We saw

that incidents were discussed monthly in the governance meetings. We looked at minutes from March 2023 and April 2023 and saw that incidents were discussed and there was learning. The practice educator did a monthly newsletter for the staff. For example, we saw in December 2022, a newsletter showed an incident that had occurred in resus regarding labelling of blood samples. The learning was highlighted and there were examples of best practice given.

Staff met to discuss the feedback and look at improvements to patient care. If there was a serious incident in the department, a team debrief would occur. Managers debriefed and supported staff after any serious incident. We were told that managers were very supportive following difficult incidents. We were told about a serious incident in the paediatric department where a child died after being brought in by ambulance. They involved the pastoral team, wellbeing team, a bereavement midwife and did a full multidisciplinary team debrief. They also followed up the individuals at home. They discussed the learning from the incident and one of the main learnings was that ambulances should not bring children to the department; we were told that this no longer happened. There was also a well-being champion who was on each shift to support staff.

The department showed that they were learning from patient deaths. They held monthly morbidity and mortality meetings and we saw learning was generated and actioned. For example, in April 2023 meeting an action was for the nurses to escalate for medical review when a patient desaturates on the NEWS.

The managers held a local incident review group to monitor their incidents; their first formal meeting was in October 2022. We saw minutes which showed that they discussed all open incidents and looked at lessons learned. For example, in March 2023 meeting, there had been a positive outcome from a theme of incidents regarding missed fractures and they were going to work with another trust to create a direct pathway.

Is the service responsive?

Good ↑

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

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Departments were designed to meet the needs of patients living with dementia. The department had recently changed their signage to purple and white in consultation with the dementia team to ensure that the signs were visible. They had received funding to improve the areas within the department for patients living with dementia or learning disabilities; they were renovating 5 cubicles to include murals and circadian rhythm lighting. All improvements were decided through speaking to patients, the mental health team, and the dementia team; we were told it was a team effort to make the changes. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

There was a limited frailty service and there was no frailty team. Patients followed the same day emergency care

pathway. We were told that there were limited community beds, this meant that some patients were admitted who were medically fit but required a bed within the community. The service were looking at implementing a "frailty at the front door" pathway however this was in its infancy stage. The trust had recently started to use virtual wards where patients were seen at home and received treatment rather than being admitted to hospital; the ED had started to use this service rather than admit some patients. There was a strict criteria for patients who were admitted to the virtual ward.

The service had information leaflets available, but they were only available in English. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff were discreet and responsive when caring for patients admitted to the department. Staff interacted with patients in a respectful and friendly way. However, due to the volume of patients using the service, and overcrowding in some areas, some patients had their conversations overheard by others and it was difficult to share confidential information privately. The service had created 5 cubicles which had glass doors which could be used to undertake difficult conversations and remain confidential.

Most patients were aware what they were waiting for in ED. Some patients were unaware of the next stage of their ED journey and this was particularly noticeable in patients who were told they were waiting for a bed to become available in the hospital, but they had no idea where or when this would be. However, the team had attempted to alleviate some of the unknown by creating bespoke boards within each area which provided an expected pathway and expected waiting times. We saw that staff updated patients about the wait where possible.

Access and flow

People could access the service when they needed it and received the right care. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. However, they were mostly better than the England averages.

Waiting times and treatment times were monitored and compared to national standards. Managers and staff worked to make sure patients did not stay longer than they needed to where possible. There were systems to manage the flow of patients through the ED and to discharge or to admit patients to the hospital. Senior managers could view the length of time each patient had been in the department, and what they were waiting for, including speciality reviews or bed admissions. The system displayed the number of patients arriving at ED from ambulances and by walk-ins. There was access to the ambulance log which showed how many ambulances were coming into the department; this meant that they could prepare for their arrival or divert them to another hospital if they were an inappropriate transfer. For example, if the staff saw that a patient who had suffered a stroke was attending, they would speak to the crew as they no longer took acute stroke patients via ambulance. The data was discussed at bed meetings 3 times a day and actions were generated from this. The staff completed a safety thermometer record 4 times a day which gave an up-to-date view of the department and RAG rated it; this created an action plan based on the rating. However, due to the number of people using the service, and capacity issues within the rest of the hospital, there were long delays in accessing assessment, treatment and admission or discharge, and national targets for ED care were not met. We observed that staff recognised when the department was coming under pressure and were proactive in decanting patients to other areas to keep all patients safe.

There was a live dashboard for the department which showed the ED's performance and where the patients were within the department, who they were allocated to and how long they had been there. On Wednesday 26th April 2023 at 9:18am, we saw that there were 35 patients in the department with 24 in majors, 5 in paediatrics, 1 in resus and 2 in UTC; 3 were awaiting allocation. We saw that 14 patients had been given a decision to admit but none of these had an allocated bed; they were all in majors and all had been waiting over 4 hours in ED. Their performance against the 4-hour

national target overall was 45.95% and 75.68% for non-admitted patients and 21.43% for admitted patients. One of the main reasons for patients waiting was the lack of beds in the hospital and late discharges. For example, on 25th April 2023, there were 44 patients discharged within the hospital but 60% of these patients left after 5pm. This had been escalated and there was a big push for a 'golden' patient to be identified the day before on each ward and prepared for their early discharge the following day. This would give 12 beds before 12pm and release the pressure within the ED.

There were standard operating procedures in place to allow patients to be cared for in ambulances or in the corridor when the ED capacity was exceeded. These procedures identified how and who should make decisions and how the situation should be escalated. There was a criteria for the patients who should be moved into the corridor to reduce the risks. Patients on the ambulances were admitted mostly in a timely manner and were not held on the ambulances for long periods of time.

During our last inspection, we found that the service was mostly worse than England average for performance. We found that whilst there were still delays in the department, this was being experienced across the country and not unique to this ED. We looked at the data and compared the results to the England average and found that in most of the areas, they performed better than England average over the last 12 months.

The ambulance handover within 15 minutes was lower than national average at 11.2% in January 2023 compared to England average of 24.4%. The percentage of ambulance handovers taking between 15 to 30 minutes had been above the England average over the last year. From March to November 2022, it was between 81% to 85% and has since seen a small increase to 85% in March 2023. The service was around 19% better than the England average for most of 2022 and this improved in 2023 where the service was 30% better than the England average.

The service had a low percentage of ambulance handovers taking over 60 minutes over the last year. Ambulance handover over 60 minutes was high over December 2022 and January 2023 at 15.3% and 11.3% respectively; however, this was better than the national average of 18.3%. Despite the rise in December 2022 and January 2023, it has since dropped back to below 5% and remained beneath the England average. In March 2023, the percentage of handovers over 60 minutes was a quarter of the national average.

The percentage of ambulance handovers taking between 30 to 60 minutes was similar to the England average from March to November 2022 (20% to 33%). Since November 2022, the service has had a higher percentage than the England average and had a peak in December 2022 at 52.33% and then falling after to 29.36% in February 2023. The mean handover time remained stable and below the England average by about 10 minutes from March to November 2022. In March 2023, the mean handover time (27:33) was longer than England's average (25:42) after a small increase from February 2023.

The national standard for patients to receive same day emergency care was 40%; in January 2023, 45.6% of patients were seen on the same day; this was better than the England average of 34.6% and had steadily improved over the last 12 months.

There was an increase in the average time to initial assessment from 11 minutes in September 2022 to 17 minutes in January 2023. The percentage of patients who received an initial assessment within 15 minutes of arrival had improved from 32.7% in December 2022 to 50.4% in February 2023.

In April 2023, 76% of patients were seen within 4 hours of arrival into the department; this was in line with the new national mandate, published 15 June 2023, which expected 76% of patients to be admitted, transferred or discharged within 4 hours. The percentage of patients waiting over 4 hours from October 2022 to February 2023 had seen large

changes each month with peaks of 41% and lows of 12%. On average, patients waited 93 minutes in January 2023 from being seen to receiving treatment; this was better than the England average of 108 minutes. From 23 March to 2 April 2023, there was an increase from 25.6% to 31.4% of patients being treated within 60 minutes of arrival.

Throughout April until October 2022, 0% of patients remained in the department for longer than 12 hours. The pressures in the department had increased and 6.7% of patients in January 2023 waited longer than 12 hours. There were insufficient beds available in the rest of the hospital to accommodate all the patients in ED who needed admitting. Managers told us that this was impacted by the lack of available community beds for patients to be discharged into. This meant that patients who needed placement in community care were staying in the hospital beds which reduced the number of available beds for ED.

On the day of our inspection, there were 13 patients in ED waiting for a bed in the trust. The number of patients waiting over 12 hours from the decision to be admit to admission was 0 until December 2022 and January 2023 when a small number of patients (10 and 16) waited over 12 hours. In April 2023 the number was 1.

There were delays in specialists reviewing their patients in ED. The Inter-Speciality Professional Standards document required specialities to review their patients in ED within 30 minutes of receiving the referral. The service did not record how long it took for a speciality review. They recorded the time from referral to time of decision to admit. On average, between 13 April and 27 April 2023, patients waited 178 minutes from their time from referral to the decision to admit them; the longest average wait was for the medicine team which was 233 minutes and surgery took an average of 157 minutes. This was on the department risk register.

The percentage of patients that reattended within 7 days of the previous attendance since February 2021 has been better than the England. In January 2023, the percentage was 1.2% this was better than the England standard of 5%. The service recognised that they had missed a few patients who had reattended within 72 hours with the same presenting condition. They had since ensured that these patients were automatically highlighted in red on their computer system and reviewed by a consultant. This meant that it was clear that they had been seen in the department within the last 72 hours.

The number of patients leaving the service before being seen for treatments was low. The service was consistently below the England average. As of January 2023, 3.5% of patients left before being seen having dropped from 5% in December 2022.

Since January 2023, 27.3% of patients were discharged, admitted or transferred within less than 2 hours after their arrival. The England average is 21.0%. There were 49.1% of patients admitted from ED still in the department 6 hours after their arrival; the England average was 63.0%. Data showed that 46.2% of patients who were admitted as an emergency had a zero-day length of stay; the England average was 37.4%.

We found that the managers were actively trying to find solutions to solve their limited space and capacity within the department. For example, they had found that they needed a further 3 resuscitation beds to run the department effectively; they had put in a business case for a further 3 to be put into the department in an area which was not well utilised. They also had put in a case to expand the department to have a first floor which CAU would move into to improve the footprint of the department. There was an action log to improve the 4-hour performance wait which showed that actions had been completed. Actions included managers to ensure patients who were identified as to be discharged the next day ‘golden patients’ were prepared for discharge to ensure beds were free earlier the following day, managers to review the utilisation of the clinical observation area and introduction of a second medical registrar at night to reduce the waiting times in ED overnight.

Urgent and emergency services

Is the service well-led?

Good ↑↑

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The senior leadership team for emergency care was led by a triumvirate consisting of the head of nursing, clinical director, and a general manager. They were all experienced leaders with strong decision-making abilities. They had the appropriate levels of operational knowledge to lead the department in pressurised circumstances. There were 2 emergency care consultants who were responsible for clinical care in the department and radiology, and who worked alongside the 2 matrons, 1 for ED and 1 for CAU, to provide local leadership direct to the ED team. The triumvirate had their offices within the department and attended the department daily. All staff members told us that they were very approachable and visible. A member of staff told us that the leadership team had "done wonders". The senior leadership team met weekly to discuss quality in the department and told us that they were united in their approach. They shared learning and good practice and standardised documentation and new processes across both ED's within the trust.

There was a team of band 7 nurses who managed and ran the department daily alongside the matron. The managers were very visible in the department. Staff knew who they were and how to contact them if they needed support. Leadership was clear, positive, and collaborative. We saw a dedicated and professional team of staff across all grades. It was clear from all staff we spoke with that leaders were supportive of their staff and passionate about their service. They were aware of how the ED environment and pressures in the workplace affected the welfare of their staff and they involved the staff in changes. They worked hard to ease the pressures of working in such a busy environment. We were also told that the executive team were very visible and listened to the needs of the department and actioned what was needed.

Within CAU, there was a matron and ward manager who oversaw the nursing team. The ward manager had recently been employed which had strengthened the leadership within the department.

The nurse in charge of the shift had responsibility for overseeing the smooth running of the whole department, including monitoring waiting times, ambulances, and moving staff around the department to cope with demand and capacity. They worked closely throughout their shift with the lead consultant and escalated patient concerns to senior managers when and if appropriate. They completed a safety thermometer 4 times a day which gave a clear RAG rating of the level of the department and actions were taken to support the department when indicated.

The ED management team had created career pathways to develop the staff including a leadership pathway which was mapped against appraisals.

The operational managers for ED and CAU attended a capacity flow meeting 3 times a day. They discussed the patient breaches and what beds were required for patients to help the flow through the department. The managers had a good relationship which enabled them to proactively manage with the flow through the departments together. The senior nurses also completed on calls for the hospital which meant that they had an overall view of the flow within the hospital.

Urgent and emergency services

Senior staff in the department were fully aware of the challenges they faced and felt the full responsibility of delivering a safe service for all. The medical team and the nursing team mostly worked well together. Most staff we spoke to said that they had a good relationship with the doctors. We were also told that in March 2023, the clinical director had spoken to the medical team and asked them to be more visible in the clinical area as had had feedback that they were intimidating when they were all in the office together.

Staff development was encouraged at all levels and senior staff told us they wanted to 'grow their own' senior staff and recently a few members of staff had been promoted within the ED.

Vision and Strategy

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

We found at the last inspection that there was no clear strategy for the department. The ED had developed a 2023/24 strategy and vision by the managers alongside the staff. The vision for the service was to 'deliver high quality, safe and effective care to our patients and provide an outstanding environment to work for our staff'. They had created team values which included promoting a no blame culture, promoting staff development, and ensuring they had effective processes to manage the patient pathways and improved clinical outcomes. They had 3 main ambitions across ED and CAU which were:

- Deliver the best possible level of safe and effective care.
- Provide education, support, and development for their staff to deliver excellence in practice.
- Actively participate in innovation, research, and collaboration to transform their service.

They had also developed key priorities and the number 1 priority was the wellbeing of their staff. We saw that some actions had already been put into place. For example, a twilight nurse shift was introduced to support the higher demand seen later in the afternoon. The leaders of the service were very aware of the strategy and had written it alongside the staff.

The strategy was clear about the barriers and risks to delivering its 2023-24 targets such as workforce, demand and the CAU estate. The service had priorities which included reducing the 12 hour waits to 0 and no more than 2%, minimising delay handovers between the ambulance and hospital, planning for winter and increasing the number of streaming pathways to support the flow through the department. To do this they had a number of initiatives including mapping patients journeys through the ED, work on a project to improve the waiting area, full capacity and demand modelling to identify gaps in the service and develop an ED shared decision making council across the directorate with a full multidisciplinary team approach. The strategy included success measures and timescales for completion.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We found at our previous inspection that the culture was poor and there was lack of cohesion between the multidisciplinary teams. During our inspection, nurses and doctors in the ED spoke very highly of each other and worked well as a team. There was a good understanding between staff in different roles and the pressures they each faced; there

was a very inclusive culture. All staff spoke highly of the local team. ED nurses and doctors mostly worked well together. The leaders described the team as going from "strength to strength", they said that they were sharing ideas, challenging each other, and putting patients first. The managers said that this relationship was previously poor and was improving through more visibility of the consultants and an open culture. A few nurses told us that whilst the culture had improved, there was still a distinct gap between the doctors and nurses and some consultants were more approachable than others. Whilst we were in the department, we saw the nurse in charge and lead consultant working well together to lead the team. They held a joint meeting at 2pm with all staff present to go through all the patients within the department and ensure there was a plan; there was a joint approach to managing the shift.

The department completed a staff survey in 2022; 35% of staff completed the survey. The survey highlighted that staff did not feel recognised or rewarded. They had developed an action plan against the survey results. The managers said that they were committed to working with the staff to further understand how this could be improved.

There was a feedback box for staff to anonymously share their feelings and concerns with the managers. Nursing staff said they knew who to approach if they had concerns and some told us they had raised issues with line managers or matrons in the past and that they had been supported and encouraged in this process. Staff told us they felt comfortable in reporting incidents, and they always received feedback.

Clinical leaders were highly visible in the department, and it was clear they were respected by their teams. There were daily huddles where staff could raise issues. The managers told us they were intending on reinstating team meetings but had found it hard to do this whilst the department had been under pressure during the winter.

Junior doctors spoke highly of their training experiences in the department and said their consultants were very approachable. A consultant told us that having the main desk in the middle of the department where the consultant in charge remained had helped with the culture. They were able to oversee all the patients in the department and staff felt able to approach them and discuss clinical cases with them; we saw this happen many times whilst we were in the department.

The department was often overwhelmed with patients and there was not always enough staff to carry out all the required tasks in a timely manner. The managers recognised this and stepped in to help when required. We saw the matron assisting staff when there were high numbers of patients being cared for.

Managers recognised the need to improve the wellbeing of their staff in a very busy and at times, chaotic environment. The band 7s had introduced a 'talking Tuesday' for staff to be able to drop in and offload if required. Each shift had a wellbeing nurse nominated for staff to approach throughout the shift if support was needed. They completed wellbeing checks throughout the shift such as ensuring all staff had received breaks. They had recently employed a member of staff in the management team who had come from the wellbeing team and were hoping to add some support in for the staff following their appointment into post.

The values and behaviours expected were displayed within the ED for staff to see. They included effective and open communication, challenge but support, and expect respect and dignity. We were told that mostly staff displayed these values but at times they did not due to the pressures within the department.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Systems were in place to assess, monitor and improve the quality of care within the ED. Governance processes were effective to ensure that the service was always safe and performed well. The ED had monthly governance meetings; they reviewed performance, incidents, complaints, risks, training, and audits. All staff were invited to attend this meeting and regardless of the pressures within the department they did not cancel this meeting. There was an action log which showed that the team acted promptly to make improvements where possible.

We found that improvements had mostly been made in relation to concerns raised at our previous inspection. For example, at our previous inspection, we found that there was not enough consultant cover to meet the national guidelines and the consultants in charge were not able to demonstrate a situational awareness of the risk within the department. During this inspection, we found that they had nearly a full establishment of consultants, they had reconfigured the department so that there was a central desk for the lead consultants and nurse in charge to work collaboratively and have full oversight of the patients within the department. They had meetings throughout the day where they asked staff who their riskiest patients were. We saw that they had put in improvements to the rapid assessment triage and treatment area to increase the number of beds from 4 to 8. They had also added a triage to the front door of the ED to ensure that patients were seen by the right people and rapidly if required. We saw that managers acted on feedback from patients. For example, they installed visual screens in the waiting area to go alongside their audio information regarding waiting times; this was following feedback from a patient who was hard of hearing.

We previously found that the governance process was not robust; action plans were not followed, and audits were not used effectively. We found that this had significantly improved. There was a monthly governance board meeting which fed into the executive risk committee; this was seen as a safety critical meeting and was not cancelled. There was a governance coordinator who managed the data, reported it monthly, created information to update staff and produced information packs for the governance meetings. There were sub committees such as the risk review meeting and incident review meetings which occurred monthly. These were attended by the main ED, CAU, diagnostics, operations, matrons, band 7's and the practice development nurse. These meetings were started to ensure that the loop was closed with incidents and actions were meaningful. The managers wanted to foster an open environment for the staff and had a no blame culture. There were 2 consultant governance leads who fed into the governance board and shared learning with the medical staff. However, we did not always see action plans associated with audits. For example, the documentation audit did not have action plans associated with them. This meant that we were not assured that actions were taken to improve practice.

The operations manager had developed new software which gave a constant live update of the department. This was shown on a large screen within the main ED and could be accessed by all managers at any point within the day. This meant that there was always oversight of the current picture within the department.

CAU was previously under the Women's and Children's Directorate and had recently moved to be managed by the urgent and emergency care division. This meant that there was 1 governance report and shared learning between the areas. There were clear pathways to escalate concerns regarding lack of capacity within the department. They had created and implemented the safety thermometer which was completed 4 times a day by the nurse in charge and formulated a RAG rating. This gave a picture of the safety of the department and depending on the rating, had clear escalation actions. We saw that this was in place on the day of inspection and saw that the RAG rating reduced from red at 8am to amber at 12pm due to actions taken by the team to review and move patients.

The team had introduced local safety standards for invasive procedures (LocSSIPs) for certain procedures in the department. This was being driven by the head of nursing who was ensuring procedures were standardised and carried out to minimise the risk to patients. This was audited between November 2022 and March 2023 for fascia iliac block and

chest drain insertion. The audit showed that some clinicians were failing to document compliance with the standard procedure and safety checks for every procedure. They had done 3 rounds of audits and whilst they had improved from 52% and 20% respectively to 58%, they were below the trust target of 75%. The audit was fed-back to the staff and will be re-audited in August 2023.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The managers actively tried to reduce the waits for patients within the department. They were better than the England average for most areas of the emergency access standards. There was real time oversight of breaches through their electronic system, use of safety thermometer, OPEL status, safety huddle and a bronze meetings 3 times a day, which was attended by the ED clinical team. There was a full capacity protocol and escalation plan in place when there were capacity issues within the department. It was a clear plan of actions with a criteria for activation for leaders to follow. However, there were still long waits within the department and these meetings did not always lead to action to solve these problems due to lack of overall capacity within the trust and community.

The department risk register listed 13 risks. There were 9 high-level risks and 4 moderate-risk; most of which were lowered to some degree by mitigating actions. The 3 highest risks were:

- The sluice within majors,
- Compliance with safeguarding level 3 training,
- Flow related issues,
- Patients presenting with mental health illness not receiving their care in line with national guidance.

The service had put actions into place to mitigate the risks for patients. For example, the managers rated the risk for mental health patients not receiving their care at 15 (high risk). This was due to the potential that patients might wait extended periods of time, especially out of hours, to be seen by an appropriate mental health professional. This had been added in 2019 and had created actions including working with stakeholders to develop robust pathways. This risk had been updated on 2 May 2023 stating that the acute mental health liaison team had increased their workforce to 2 practitioners who were available 24 hours a day, 7 days a week. They had also seen improvements with 90% of patients being reviewed within 60 minutes. There were still delays for patients requiring a consultant review but there was a robust process in place for referrals.

Risks remained for patients who were waiting a long time in the ED. The senior leadership team had instigated some plans to reduce the risks for these patients. For example, patients who were waiting on trolleys for a long period of time were moved onto a bed for increased comfort and to reduce the chance of developing pressure sores. There had been no pressure area damage recorded in ED in 2023.

There was a risk review group who met bi-monthly and reviewed the outstanding risks on the risk register and put any actions into place if required. Risks were communicated to staff via a monthly poster or via an encrypted closed communication application. We saw a poster for March 2023 which showed staff the high risks within the department which included delay in speciality review, overcrowding and increase in time to triage.

It was not possible to mitigate all the risks associated with running a department at over capacity, and when there were high numbers of patients in the department it was difficult to have thorough oversight of every patient. Opportunities

existed for patients to deteriorate rapidly without being detected. For example, some walk-in patients were in the department for a while before a set of observations were recorded. However, the department had tried to reduce the risks by having a triage nurse at the entrance to the ED to do a pre-triage assessment, there were communication meetings led by the consultant and nurse in charge to ensure high risk patients were identified and the managers were looking at ways to improve the layout of the building and constantly applying for funding to improve their services; many of which had been approved and put into place.

The main risk within CAU was the lack of space and flow due to there being no paediatric beds within the hospital. This meant that at times there was a long wait for a transfer to another hospital and reduced the capacity within the department.

The managers had also linked up with other ED's within their foundation group to share learning. They had set up a senior nurse forum across the system and shared ED processes with other departments. They had also visited different ED's for learning.

There was a monthly mortality and morbidity meeting which was attended by all consultants. They took place every 2 weeks to discuss any deaths which had occurred unexpectedly in the ED and were used to identify learning and reduce risks to patients. We looked at minutes from January and February 2023. We saw that 23 deaths had been discussed including areas of good practice and learning points. We saw that from all of these 23 deaths, no learning points had been identified. A consultant told us that a recent theme was patients being brought into the department when they were on end of life care and this was against their wishes. They had fed this back to GP's and paramedics and seen a recent improvement.

Areas for improvement

SHOULDS

- The trust should ensure that all staff complete life support training appropriate to their level (Regulation 12).
- The trust should ensure that all staff complete level 3 safeguarding adults and children's training (Regulation 13).
- The trust should consider labelling equipment once it has been cleaned.
- The trust should ensure sepsis paperwork is completed and the sepsis 6 bundle is actioned within the 1 hour timeframe (Regulation 12).
- The trust should implement and consider monitoring the use of PEWS in line with their new policy.
- The trust should ensure that all staff complete the nursing documentation booklets thoroughly including the patient safety checklist (Regulation 12).
- The trust should ensure that the venous thromboembolism risk assessments are carried out in line with national guidance (Regulation 12).
- The trust should ensure that out of range fridge temperature checks are acted upon to ensure the safe storage of medicines (Regulation 12).
- The trust should continue to work towards meeting the national targets for providing timely patient care. (Regulation 12).

Urgent and emergency services

- The provider should ensure that all audits have an associated action plan when they fall below compliance. (Regulation 17).

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 1 other CQC inspector, and a specialist advisor with expertise in emergency medicine. The inspection team was overseen by Karen Richardson, Operations Manager.