Worcestershire Acute Hospitals NHS Trust

Inspection report

Worcestershire Royal Hospital
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The Worcestershire Acute Hospitals NHS Trust serves the population of Worcestershire and neighbouring counties from three main sites, Worcestershire Royal Hospital in Worcester, Alexandra Hospital in Redditch and Kidderminster Hospital and Treatment Centre. According to the Trust's website, in 2021/22 they provided care to more than 250,000 different patients including 166,904 A&E attendances, 151,357 inpatient episodes, 501,478 outpatient appointments and 4,939 births.

The 500-bedded Worcestershire Royal Hospital opened in 2002. It provides specialist services for the whole of Worcestershire including stroke services and cardiac stenting. The Worcestershire Oncology Centre opened in January 2015, providing radiotherapy services for cancer patients, the first time these services have been available in the county.

Alexandra Hospital has around 300 beds and was opened in 1985. The hospital is the major centre for the county's urology services. Following a commissioner-led review of acute services across the county which concluded in July 2017, emergency surgery, maternity, neonatology, emergency gynaecology and inpatient paediatrics were centralised and moved away from the Alexandra Hospital in Redditch to the Worcestershire Royal Hospital site.

Kidderminster Hospital houses the Kidderminster Treatment Centre which offers day case, short stay and inpatient procedures. The hospital also has a nurse-led minor injuries unit, and a range of outpatient clinics including outpatient cancer treatment and a renal dialysis unit.

The trust carries out the following regulated activities;

- Maternity and midwifery services
- Termination of pregnancies
- Family planning
- Treatment of disease, disorder or injury

Our findings

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Surgical procedures
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products

We carried out this short notice announced comprehensive inspection on 21, 22 and 23 November 2022. The following acute services provided by the trust were inspected:

- Urgent and emergency care at Worcestershire Royal Hospital and Alexandra Hospital.
- Medical care (including older people's care) at Worcestershire Royal Hospital and Alexandra Hospital.

Urgent and emergency care and Medical care (including older people's care) services were last inspected in 2019.

Services previously rated but not inspected at this time include:

Worcestershire Royal Hospital

- Surgery, Critical Care, Maternity, Services for children and young people, End of life care, Outpatients and Diagnostic Imaging.

Alexandra Hospital

- Surgery, Critical Care End of life care, Outpatients and Diagnostic Imaging.

Kidderminster Hospital and Treatment Centre

- Urgent and emergency care, Medical care (including older people's care), Surgery, End of life care, Outpatients and Diagnostic Imaging.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated effective and caring as good. We rated safe, responsive and well-led as requires improvement.
- We rated all four of the services we inspected as requires improvement overall.
- Patients were not always protected from harm. Staff, particularly medical staff, did not always have up to date training in key skills including safeguarding training. Staff did not always manage medicines safely. There were handover delays for patients arriving by ambulance.
- Facilities were not always appropriate for the services being delivered in them.
- Not all staff felt respected, supported and valued.

However;

- The service generally had enough staff. Staff treated patients with compassion and kindness and respected their privacy and dignity. They gave them enough to eat and drink, took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.

Our findings

- Services generally provided care and treatment based on national guidance and evidence-based practice. Staff monitored the effectiveness of care and treatment. The services made sure staff were competent for their roles. Staff worked together as a team to benefit patients. Key services were available to support patient care.

How we carried out the inspection

We visited areas relevant to each of the core services inspected and reviewed 46 patient records. We spoke with 117 staff members of various professions and specialities including doctors, nurses, healthcare assistants, students, pharmacists, ambulance staff and domestic staff.

We spoke with 44 patients and 4 relatives.

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

Use of resources

The use of resources was not inspected on this occasion.

Combined quality and resource

The combined quality and resources was not inspected on this occasion.

Outstanding practice

Worcestershire Royal Hospital

Medical Care (including older people's care)

A clinical nurse specialist on Acute Respiratory Unit ran a pleural effusion service, inserting chest drains. Alongside booked patient clinics, they went into the emergency department to identify people that they could treat within their clinic as an outpatient and avoid unnecessary admissions.

Urgent and Emergency Care

The Worcestershire Royal emergency department had a proactive approach to staff welfare that took account of the recent pandemic and the stress that the staff were under. There was a particular focus on supporting staff who had suffered violence or aggression and we saw good leadership of this aspect of staff support.

Alexandra Hospital

Urgent and Emergency Care

We saw a one to one outstanding caring episode where a healthcare assistant was looking after a patient living with dementia. They were drawing, completing word searches and reading books together.

Our findings

Areas for improvement

Areas the trust MUST improve

Worcestershire Royal Hospital

Medical Care (including older people's care)

- The trust must ensure that risks to patients admitted to Discharge Lounge and Pathway Discharge Unit, particularly against unit standard operating procedures, are assessed and mitigated as far as possible (Regulation 12(2)).

Urgent and Emergency Care

- The provider must ensure they manage the capacity and flow in the emergency department to prevent patients waiting too long (Regulation 17(1)).
- The trust must ensure patients have timely access to the emergency department in line with national standards (Regulation 17(1)).

Alexandra Hospital

Medical Care (including older people's care)

- The trust must ensure that there are safe process and systems in place to manage the prescribing, storage and monitoring of medications (Regulation 12 (2 g)).
- The trust must ensure that risks to patients admitted to Discharge Lounge, particularly against unit SOPs, are assessed and mitigated as far as possible (Regulation 12(2a)).

Urgent and Emergency Care

- The provider must ensure they manage the capacity and flow in the emergency department to prevent patients waiting long times (Regulation 17 (1)).
- The provider must ensure that patients are not waiting a long time in ambulances outside of the emergency department and they work with the local systems to improve patient flow (Regulation 17 (1)).

Areas the trust should improve

Worcestershire Royal Hospital

Medical Care (including older people's care)

- The trust should ensure that medical staff stay up to date with mandatory training including, but not limited to, safeguarding training and training on the Mental Capacity Act and Deprivation of Liberty Safeguards (Regulation 12).
- The trust should ensure that patient ‘pods’ on Laurel 2 ward adhere to infection prevention and control standards at all times (Regulation 12).

Our findings

- The trust should ensure that there is enough suitable equipment available to enable staff to care for patients (Regulation 12).
- The trust should ensure that systems and processes to prescribe and administer medicines safely are followed (Regulation 12).
- The trust should ensure that incidents are investigated, and lessons are learned on all units (Regulation 17).
- The trust should ensure that access to specialist stroke services is improved for patients (Regulation 12).
- The trust should ensure that all aspects of poor performance in national audits are addressed (Regulation 17).
- The trust should ensure that records are always safely and securely stored (Regulation 12).
- The trust should consider extending therapy and pharmacy cover to Pathways Decision Unit.
- The trust should consider ways to improve staff morale and visibility of leaders for all staff.

Urgent and Emergency Care

- The trust should ensure that female genital mutilation and child sexual exploitation are incorporated in the mandatory training programme.
- The provider should ensure that medical staff are up to date with their mandatory training. (Regulation 12)
- The trust should ensure that there is a suitable decontamination area that is available for immediate use (Regulation 15).
- The provider should make the emergency department corridor care more dignified for patients.
- Staff should assess, monitor and manage patients' pain in a timely manner. (Regulation 12)
- The service should ensure that medicines are stored safely and appropriately (Regulation 12).
- The trust should ensure complaints are responded to in a timely manner, in line with their policy
- Managers should ensure services are planned to meet the needs of the local people.

Alexandra Hospital

Medical Care (including older people's care)

- The trust should ensure that medical staff stay up to date with mandatory training including, but not limited to, safeguarding training and training on the Mental Capacity Act and Deprivation of Liberty Safeguards. (Regulation 12).
- The trust should consider ways to improve staff morale and visibility of leaders for all staff. (Regulation18).
- The trust should ensure leaders at the service have oversight of the risks to patients or take action to reduce the risks. (Regulation12).
- The trust should ensure that key information to keep patients safe when handing over their care to others is improved. (Regulation12).
- The trust should ensure they have dedicated medical staffing for the discharge lounge to reduce the risk to patients. (Regulation12).
- The trust should work to improve the appraisal rates for staff to meet the trust target of 90%.

Our findings

Urgent and Emergency Care

- The provider should consider using signage which encourages the community to attend an appropriate paediatric department.
- The provider should consider running more Advanced Life Support courses to improve access for staff.
- The provider should ensure that medical staff are up to date with their mandatory training (Regulation 12).
- The provider should make the emergency department corridor care more dignified for patients (Regulation 10).
- The provider should improve its management of Sepsis 6 and ensure that it meets the 1 hour target (Regulation 12).
- The provider should consider a more robust approach to record storage.
- The provider should ensure that staff have completed their paediatric competencies (Regulation 12).
- Staff should assess, monitor and manage patients' pain in a timely manner (Regulation 12).
- The service should ensure that medicines are stored safely and appropriately. (Regulation 12)
- The service should consider arrangements for clinical pharmacy support for the emergency department.
- Managers should ensure services are planned to meet the needs of the local people (Regulation 17).
- The provider should ensure that staff have the appropriate level of safeguarding training (Regulation 13).
- The provider should ensure that there is no duplication of medication charts (Regulation 12).
- The managers should ensure that they embed the vision and strategy within the department.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Apr 2023	Good →← Apr 2023	Good →← Apr 2023	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023	Requires Improvement →← Apr 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Mental health	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ➔➔ Apr 2023	Good ➔➔ Apr 2023	Good ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Alexandra Hospital	Requires Improvement ➔➔ Apr 2023	Good ➚ Apr 2023	Good ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➘ Apr 2023	Requires Improvement ➔➔ Apr 2023
Evesham Community Hospital	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Kidderminster Hospital and Treatment Centre	Good Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019
Worcestershire Royal Hospital	Requires Improvement ➔➔ Apr 2023	Good ➔➔ Apr 2023	Good ➔➔ Apr 2023	Requires Improvement ➘ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023
Overall trust	Requires Improvement ➔➔ Apr 2023	Good ➔➔ Apr 2023	Good ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023	Requires Improvement ➔➔ Apr 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Apr 2023	Good ↑ Apr 2023	Good →← Apr 2023	Requires Improvement ↓ Apr 2023	Requires Improvement ↓ Apr 2023	Requires Improvement →← Apr 2023
Services for children & young people	Requires improvement Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Critical care	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
End of life care	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Maternity and gynaecology	Requires improvement Jun 2017	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017	Requires improvement Jun 2017	Requires improvement Aug 2017
Surgery	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019
Urgent and emergency services	Requires Improvement ↑ Apr 2023	Good ↑ Apr 2023	Good →← Apr 2023	Requires Improvement ↑ Apr 2023	Requires Improvement ↑ Apr 2023	Requires Improvement ↑ Apr 2023
Diagnostic imaging	Requires improvement Sep 2019	Not rated	Outstanding Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Outpatients	Good Sep 2019	Not rated	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019
Overall	Requires Improvement →← Apr 2023	Good ↑ Apr 2023	Good →← Apr 2023	Requires Improvement →← Apr 2023	Requires Improvement ↓ Apr 2023	Requires Improvement →← Apr 2023

Rating for Evesham Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Overall	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019

Rating for Kidderminster Hospital and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Services for children & young people	Requires improvement Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Maternity and gynaecology	Requires improvement Jun 2017	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017	Requires improvement Jun 2017	Requires improvement Jun 2017
Surgery	Good Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019
Diagnostic imaging	Good Sep 2019	Not rated	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Outpatients	Good Sep 2019	Not rated	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019
Urgent and emergency services	Requires improvement Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Overall	Good Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019

Rating for Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Apr 2023	Good ↑ Apr 2023	Good → ← Apr 2023	Requires Improvement → ← Apr 2023	Requires Improvement ↓ Apr 2023	Requires Improvement → ← Apr 2023
Services for children & young people	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Critical care	Requires improvement Jun 2017	Good Jun 2017	Good Jun 2017	Requires improvement Jun 2017	Requires improvement Jun 2017	Requires improvement Jun 2017
End of life care	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Surgery	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019
Urgent and emergency services	Requires Improvement ↑ Apr 2023	Good → ← Apr 2023	Good ↑ Apr 2023	Requires Improvement ↑ Apr 2023	Requires Improvement ↑ Apr 2023	Requires Improvement ↑ Apr 2023
Diagnostic imaging	Requires improvement Sep 2019	Not rated	Good Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Maternity	Requires improvement Feb 2021	Good Feb 2021	Good Jun 2018	Good Jun 2018	Requires improvement Feb 2021	Requires improvement Feb 2021
Outpatients	Requires improvement Sep 2019	Not rated	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019
Overall	Requires Improvement → ← Apr 2023	Good → ← Apr 2023	Good → ← Apr 2023	Requires Improvement ↓ Apr 2023	Requires Improvement → ← Apr 2023	Requires Improvement → ← Apr 2023

Alexandra Hospital

Woodrow Drive
Redditch
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Description of this hospital

Alexandra Hospital

Medical Care (including older people's care):

Our rating of this location stayed the same. We rated it as requires improvement because:

- Staff did not always have training in key skills. Mandatory training levels for medical staff did not meet the trust target of 90%.
- The service did not always have effective processes in place to protect patients from harm during the discharge process. Patients were regularly admitted onto discharge units against standard operating procedure criteria.
- The service did not always have safe process and systems in place to manage the prescribing, storage and monitoring of medications.
- Not all staff felt respected, supported and valued.
- Leaders at the service did not always have oversight of the risks to patients or take action to reduce the risks.
- Staff did not always share key information to keep patients safe when handing over their care to others.
- The service did not have dedicated Medical staffing for discharge lounge, causing delays in discharge and risks to deteriorating patients.
- Medical staff did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- The service had enough staff to care for patients and keep them safe. Most 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, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- 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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

We inspected this service on 21, 22 and 23 November 2022. This was an unannounced full core service inspection looking at medical care. We visited all medical wards and speciality services. Areas we visited during our inspection included:

- Ward 1 (Discharge Lounge)
- Ward 2
- Ward 3
- Acute Medical Unit
- Acute Emergency Care
- Medical Short Stay Unit
- Endoscopy
- Cardiology
- Ward 11 – Frailty Ward and General medicine
- Ward 12-– Frailty Ward and General medicine
- Ward 18 – Pathway Discharge Unit

The team that inspected the service comprised of 1 CQC inspector, 2 Inspection Managers, 1 Assistant inspector and a specialist advisor with expertise in medical care.

During our inspection we spoke with 15 staff members including nursing staff, healthcare assistants, medical staff and managers. We spoke to 8 patients and we reviewed 10 sets of patient records.

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

Urgent and Emergency Care:

Our rating of urgent and emergency care improved. We rated it as requires improvement because:

Our findings

- Staff did not always have training in key skills. Mandatory training levels for medical staff did not meet the trust target of 90%.
- Staff did not always have the training in safeguarding at the appropriate level.
- Patients were being cared for in the corridor which was not always dignified.
- The service did not have paediatric nurses and not all nurses were trained in paediatric competencies.
- Staff did not always assess the risks to patients in a timely manner.
- The service had systems and processes to prescribe and administer medicines safely, however, it did not always meet the needs of the patient.
- There was a good relationship with the pharmacy service to ensure medicines were available, however, there was no clinical pharmacy service within the emergency department.
- Medicines were not always stored safely or appropriately to reduce the risk of errors.
- Staff did not always give pain relief to patients when they needed it.
- The service planning did not meet the needs of the patients.
- There were delays in moving patients off ambulances into the department. This resulted in delays in assessment and treatment for some patients.
- Staff did not understand the service's vision and values, and how to apply them in their work.
- Managers did not always have oversight for some of the issues within the department including lack of paediatric nurses, duplicating of medicine charts and lack of strategy for managing the poor flow.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse and managed safety well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Key services were available seven days a week.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

How we carried out the inspection

We inspected this service on 21 and 23 November 2022. This was an unannounced full core service inspection looking at urgent and emergency care. We visited all areas of the emergency department including the waiting rooms, resuscitation, minors, majors and early decisions unit.

Our findings

The team that inspected the service comprised 3 CQC inspectors and 2 specialist advisors with expertise in emergency medicine.

During our inspection we spoke with 44 staff members including nursing staff, healthcare assistants, ambulance staff, cleaners, doctors and managers. We spoke to 15 patients and we reviewed 18 patient records.

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

Medical care (including older people's care)

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, the mandatory training was comprehensive and met the needs of patients and staff.

Training modules included equality and diversity, infection prevention and control and Mental Capacity Act and Deprivation of Liberty training. However not all staff had completed training. Evidence we saw following our inspection showed that 89.94% of nursing staff in specialty medicine across the Worcestershire Royal and Alexandra Hospital sites were up-to-date with their mandatory training, just below the trust target of 90%. However, only 67.31% of medical staff had completed mandatory training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, the completion rate for this training was low, medical staff having completed 45.75% and nursing and clinical staff completion rate of 81.5%.

The training completion for endoscopy, haematology and oncology medical staff for Mental Capacity Act and Deprivation of Liberty training was 56.25%.

The service told us there are 9 medical staff within the Specialty Medicine Division at the Alexandra Hospital who are Advanced Life Support (ALS) trained. During our inspection we saw that the member of staff on each ward who was ALS trained per shift was identified.

The service had a system in place for monitoring training completion rates and staff we spoke with during our inspection told us they knew how to book on training and that they were given time for completion of training.

Safeguarding

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

The training compliance data for nurses and support staff showed that the overall mandatory training compliance was 86.75%, this was below the trust target of 90%. Training compliance data for medical staff showed that only 54.26% of staff had completed their mandatory training. Nursing staff above a Band 7 are expected to be trained to a level 3 for safeguarding adults and children, other staff are expected to be trained to at least a level 2.

Safeguarding policies we saw were in date and staff could explain how they would access these on the trust intranet. Staff told us they had access to a safeguarding lead and knew how to make a safeguarding referral and who to inform if they had concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. One staff member explained how a patient who was suspected to be at risk of financial abuse was supported and referred to safeguarding agencies.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas were visibly clean. The utility rooms and dirty and clean laundries were well organised and clean. Cleaning schedules had been completed daily and were up to date, patient bays had cleaning checklists. We saw cleaning staff were checking and cleaning patient areas at regular intervals during the day. Cleaning staff used 'I am clean' stickers on equipment which had been cleaned after use.

Staff followed infection control principles such as being bare below the elbow and the use of personal protective equipment (PPE). We saw staff using PPE and infection prevention control measures such as handwashing and use of antibacterial hand gel effectively. Staff were able to identify the trust lead for IPC.

The trust completed twice monthly environment quality check audits; these were completed across the division for each individual ward. Each ward was given a score of either green score (no further action), amber score (some improvements to be made) and red score (requires improvement). Areas audited included environment, hand hygiene, use of personal protective equipment and cleanliness. Staff we spoke to on inspection told us they were told about the outcomes from audit and actions to be taken. Evidence we saw following our inspection showed all wards performed well in these audits.

There were information leaflets and posters in the patient areas detailing infection prevention control measures. There were adequate supplies of antibacterial hand gel, antibacterial wipes and face masks in all areas of the unit including at the main patient entrance.

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.

The service screened patients for Clostridium difficile (C. diff) and Methicillin-resistant Staphylococcus aureus (MRSA). There had been no MRSA infections in the last 12 months. The trust report there had been 24 C.diff infections over the last 12 month period (this included community-onset healthcare associated infections) , evidence we saw showed they had taken action to reduce infections which included new assessment tools and staff education.

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.

Patients could reach call bells and staff responded quickly when called. We saw that patients had access to call bells in easy reach and staff responded to call bells and requests from patients.

The design of the environment followed national guidance. Staff disposed of clinical waste safely. We saw an adequate number of sharps and clinical waste bins and these were emptied in a timely manner.

Medical care (including older people's care)

On the wall outside most wards there was a chart detailing the matron and consultant on shift for the day. This information was not provided for the discharge lounge. On most wards there was a sign on each bay with a named nurse allocated for the day.

Staff carried out daily safety checks of specialist equipment. We checked the resuscitation trollies on 4 wards and found that checks had been completed and all items for use in an emergency were in date.

The service had enough suitable equipment to help them to safely care for patients. We checked 17 pieces of equipment and an electrical safety testing programme had been completed in line with guidelines. Other equipment checks had also been completed however we found the fridge on 1 medical ward was not in working order and could not be used for the safe storage of medications. This was escalated to the trust at the time of our inspection and action had been taken by the time of our return visit the following day to ensure that medications could be stored in working fridge.

Staff also told us that agency staff do not have access to the trust reporting systems so were unable to complete audits and access some patient information. These staff also do not have access to some wards and have at time been locked out until a substantive member of staff attends the wards. Both issues are a risk to patient safety and the trust were made aware of this at the time of our inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the service did not have dedicated medical staffing cover for the discharge lounge (Ward 1) and this meant responses for deteriorating patients could be delayed, staff told us that as the patient is officially discharged from their previous ward when they have concerns for a patient it is difficult to find a member of the medical staff to report changes in health too. However, since our inspection the trust has told us there is now close monitoring and scrutiny of the discharge lounge by the Divisional Director of Nursing and Operations.

Not all staff shared key information to keep patients safe when handing over their care to others. Staff we spoke to could evidence inappropriate referrals between wards where patient information had not been given. This meant that staff could not always be assured they had a full awareness of patients' risks and needs in relation to these areas. This could lead to the patient either being returned to the transferring ward or the patient being discharged home or to a care provider without this information causing a risk to health.

Patients who were outliers in the service were seen by a medical consultant for their speciality. An outlier patient is a hospital inpatient who is classified as a medical patient for an episode within a spell of care and has at least 1 non-medical ward placement within that spell.

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 of Health and Care Excellence (NICE), Clinical Guidance. Sets of notes we reviewed had NEWS checks and falls assessments completed where needed. In patient files we reviewed we saw that where needed there had been appropriate NEWS escalation by clinical staff.

During our inspection we reviewed a total of 12 sets of patient notes from the medical wards. Staff completed risk assessments for each patient on admission using a recognised tool and reviewed this regularly.

Staff completed assessments for the risk of pressure ulcers, falls and nutrition.

Medical care (including older people's care)

At the ward bed hand over, we attended where the morning staff are taking over from the evening staff, we saw that any changes in health or concerns about a patient were discussed and noted by staff.

The trust had a sepsis information campaign with posters highlighting sepsis and its treatment on all wards. Staff we spoke to were able to explain the assessment for sepsis and how to escalate concerns.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff we spoke to had a good knowledge of the Mental Capacity Act and Deprivation of Liberty standards and how to assess a patient and if needed access support. The trust had 24 hour support from a mental health team.

Nurse staffing

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

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. Staffing levels were reviewed daily by managers and staff moved to cover other wards if needed. However, the staffing on the discharge lounge had not been adjusted to reflect that this area was now operating as a ward with some long stay patients. Staff on the discharge lounge told us they felt the area was not always staffed correctly for the patient needs as some patients may stay longer due to issues with the discharge process and for example a dementia patient could need one to one care which they are not staffed to provide. There was also a general theme from staff that administration support on the discharge lounge would improve the management of the ward and help with the administration of the discharge process.

Over a 6 month period the service used bank or agency staff on average 17% of the time to meet the required staffing levels, this was mainly on the acute medicine wards. The ward manager could adjust staffing levels daily according to the needs of patients and a daily ward round huddle was held across the 2 trust sites to review the staffing levels and discuss any areas where extra staff maybe needed.

At the time of our inspection vacancy rates were 12.08% across the service for all specialities, and a sickness rate of 6.21%.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, staff told us they felt there was adequate medical cover and on call cover for the medical wards except for the discharge lounge.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number.

The service had vacancy rates for the cardiology service of 6.22% and acute service of 20.23%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Medical care (including older people's care)

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Staff told us they felt there was adequate medical cover and on call cover for the medical wards except for the discharge lounge. We saw that staff working in the discharge lounge had to escalate poor responses from medical staff when they were asked to attend the ward. We saw an interaction between medical staff and nursing staff and raised concerns at the time that this interaction had been poor and unhelpful.

Records

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

Records were paper-based, and staff completed them thoroughly and legibly, signing and dating where required. Records were easy to access on wards.

During our inspection we viewed 10 patient records across the medical wards. Patient notes were comprehensive, and all staff could access them easily. Patient checklists had been completed in a timely manner and patient needs had been recorded appropriately. Risk assessments had been recorded accurately and nursing plans were in place where required. Nutritional assessments had also been completed and if needed a follow up nutritional care plan had been done. The service was also completing falls assessments and taking action to mitigate the risk to the patient as appropriate. Patient records were mainly stored in paper files in lockable cupboards.

Senior nursing staff we spoke to could explain the patient file audits and actions taken from the audits and how this was communicated to staff. However, several staff on different wards said information provided was frequently incomplete, not available or inaccurate.

Medicines

The service did not always use systems and processes to prescribe and administer medicines safely. A team of pharmacists and pharmacy technicians worked within the medical assessment unit (MAU) and medical wards, however there was no clinical pharmacy service for the discharge lounge which was operating as a medical ward.

There was a good relationship with the pharmacy service to ensure medicines were available. Medicines supply from pharmacy was available and staff knew the routes to obtain medicines out of hours if required. A team of prescribing clinical pharmacists and pharmacy technicians working within MAU were an integral part of ensuring that systems and processes were followed when safely prescribing medicines.

However, the discharge lounge (operating as a medical ward) had no clinical pharmacy support. Although staff on the ward knew how to escalate concerns to pharmacy this was not always undertaken. For example, 2 patients had not been administered some of their prescribed medicines as they were not available and had not been requested from pharmacy. We were told that agency nurses had failed to inform the nurse in charge who would have ordered the medicines from pharmacy. We found that a reactive service did not always meet the needs of the ward or patients. However, since our inspection the trust have told us medicines management has been a high priority, all stock lists have been reviewed with the matron and a pharmacy technician and new controlled drug books in place with training for staff on how to manage controlled drugs ordering, storage and administration.

Staff did not always follow systems and processes when safely prescribing, administering and recording medicines. Medicines were not always stored safely or appropriately to reduce the risk of errors.

Medical care (including older people's care)

Staff did not always review each patient's medicines regularly and provide advice to patients and carers about their medicines. Staff checked patients medicine requirements on their prescription chart prior to administration. There was a dedicated clinical pharmacy service based on MAU which ensured that patients medicines were regularly reviewed and the team provided advice and support to both patients and staff where needed. However, as there was no clinical pharmacy service within the discharge lounge and due to a lack of medical cover there were no medicine reviews or clinical checks on prescribing and no medicine advice or support to staff, patients or carers.

Staff completed medicines records accurately and kept them up to date. Allergy statuses of patients were routinely recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely.

Weights of patients were recorded on medicine administration records which is important for calculating weight-based medicines prescribing. Venous thromboembolism (VTE) risk assessment outcomes and prescribing were completed on all patients notes reviewed at admission.

Staff did not always store and manage all medicines securely or safely. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. However, there was poor medicine storage and organisation. For example, in the medical assessment unit (MAU) medicine cupboards were over full which made it difficult to easily find and locate a medicine. The storage of medicines in the discharge lounge was untidy and chaotic. There were bags of patients own medicines left out on the workbench which had not been locked away. This increased the potential risk of a medicine error or a medicine not being located. We were told that Pharmacy were going to review stock lists for the discharge lounge to provide support.

Emergency medicines and equipment were available and expiry dates checked were in date. They had 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 (CDs) (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. CD discrepancies or issues were reported to the controlled drug accountable officer and would be investigated following trust policy. We saw evidence of 2 occasions where medication had gone missing or not been accounted for correctly, these had been reported and investigated and we saw the evidence of these investigations.

Medicine fridges were locked and secure with authorised staff access only. Records of medicine fridge temperatures were recorded daily and were within a safe range for medicine storage. However, the medicine fridge in the discharge lounge was broken. This had been escalated to estates to repair and action was taken during our inspection.

Staff followed national practice to check patients had the correct medicines when they were admitted, but not always when they moved between services. A medicines history was taken on arrival using the Summary Care Record which is an electronic record of patient health information created from General Practice medical records. This was recorded into the patients notes. Medicine reconciliation was undertaken by the pharmacy team within MAU following national guidance. However, due to the lack of clinical support in the discharge lounge medicines were not always checked as appropriate before the patient was discharged.

Staff learned from safety alerts and incidents to improve practice. 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.

The trust had a Medicines Safety Officer (MSO) in line with NHSE directives. The MSO investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents. Any learning was shared via newsletters or posters.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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 via an electronic reporting system. Staff said they were encouraged to report incidents and near misses. Staff we spoke to were able to give us examples of incidents they had reported. However, managers did not always receive feedback from investigation of incidents, both internal and external to the service.

Staff told us they had raised incidents about falls, patient safety and processes and staffing safety in the discharge lounge. Staff also explained that they would report failed discharges, where a patient is admitted to the discharge lounge and then due to either the patient not meeting the criteria for the discharge lounge or a deterioration in the patients' health, they are transferred back to the ward. Since the inspection, a designated matron was put in place to oversee reporting and feedback. The trust told us that all outstanding and overdue incidents and complaints had been investigated and closed, all complainants contacted individually, and that concerns had been responded to with associated actions.

The service had no never events on any medical wards.

Managers shared learning with their staff about incidents that happened elsewhere. The service communicated a 'lessons of the week' which came from Governance meetings and explored lessons learned from incidents.

Staff reported serious incidents clearly and in line with trust policy. Between 21 November 2021 and 22 November 2022, staff reported 73 serious incidents relating to the medicine specialty at the Worcestershire Acute Hospitals Trust.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. We reviewed minutes from the Mortality and Morbidity meetings held at the trust between September 2022 and November 2022. These meetings were held to review patient incidents and discuss patient care. Minutes from the cardiology review for September showed discussion of a serious incident and the actions to be taken but the minutes also highlighted areas of good practice and communication to staff.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was evidence that changes had been made as a result of feedback. One incident report we reviewed following our inspection

showed that staff had raised a serious incident via the reporting system with concerns about the safety of a patient following discharge from the discharge lounge. The staff concern raised about the patient had been followed up by manager and the report details a change in the processes for the ward to mitigate future risks for patients. The family member of the patient had been contacted and the outcome of the investigation explained.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service participated in national audits and followed national guidance on best practice for the care of patients. The service participated in SEPSIS audits and acted on the outcomes.

There were systems in place to check patients received services and evidence-based care which met best practice. The service completed weekly division wide quality check audits which included checking falls assessments and needs based assessments had been done. Feedback was given to staff on the outcomes.

There were polices and guidance available to staff, staff we spoke to were able to tell us where these policies were and how they were kept up to date with any changes.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. At a ward handover meeting we attended during our inspection staff discussed the medical needs of patients and also the patients social and emotional needs.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff told us they were able to access the mental health team for support and gave us examples of when this had been done.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients we spoke to during our inspection said they had access to food and drink. One patient explained staff made sure they had access to food 24 hours a day and were responsive to their requests. We saw that patients had drinks and where needed food within easy reaching distance. We saw red trays being used on wards to help staff identify where patients needed support with eating.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patient files we reviewed had an up to date chart and the service weekly quality audit checks were being completed in a timely manner.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff could make referrals to these teams for patient assessment and support.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately. Patient records we reviewed showed that staff assessed patients pain in a timely manner and took action.

Patients received pain relief soon after requesting it. Patients we spoke to during our inspection said they had been asked about their pain and relief had been given in a timely manner.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. This included The National Audit of Inpatient Falls, National Acute Kidney Injury Audit, National Lung Cancer Audit and UK Parkinson's Audit. Local trust audits were also undertaken such as Key Standards audits which included fridge audits. Controlled drug audits were undertaken, and we saw evidence that these had been done and outcomes communicated to staff. Staff we spoke to told us they were able to access the audit outcomes.

We reviewed the latest National Audit of Inpatient Falls by the Royal College of Physicians which assessed aspects of falls prevention and post-fall care. This included whether a high-quality multi-factorial risk assessment was performed before the fall, and whether staff adhered to NICE QS86 in their post-fall management. The trust scored above the national average on components of the multi-factorial risk assessment including whether the patient had had a lying/standing blood pressure taken (100%), a mobility assessment done (100%) and a complete delirium assessment (86%). The score for continence assessment was 32% however, significantly below the national average of 83%. Scores for checking injury before moving patients after a fall, and the use of flat lifting equipment to lift the patient were significantly above the national average. The third element of post-fall management however, medical assessment within 30 minutes, was below the national average at 57% versus 69% nationally.

Results from the latest National Acute Kidney Injury Audit in 2020 showed that staff recorded episodes of acute kidney injury accurately and completely.

Outcomes for patients were consistent with similar services and met expectations, such as national standards. Managers monitored information for patients readmitted to hospital within 48 hours and seven days. The information provided showed readmission rates were stable and minimal.

The service had an expected risk of readmission comparable to the national average. Data from September 2021 to August 2022 showed that the 30-day emergency readmission rate for the Worcestershire Acute Hospitals NHS Trust was 8.31%. This is just above the national average of 8.16%, and below the Midlands average of 9.32%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, documentation, risk assessments, consent, management of deteriorating patients and discharge. Managers shared and made sure staff understood information from the audits and implemented changes in practice when required. When audits identified a need for improvements action was taken. For example we saw the medicines optimisation report which explained that The Antimicrobial Stewardship group had monitored progress of the action plans developed to demonstrate the principles of Start Smart Then Focus and that there had been continued improvement in the participation of the monthly audits and where further improvement was needed.

Managers used information from the audits to improve care and treatment. Managers reviewed local audit results and themes and added actions to the Division's action tracker spreadsheet. They discussed any outstanding or overdue action at weekly Divisional Governance Meetings. Staff in the acute medical unit told us that there had been an increase in pressure ulcers and there was a plan in place to improve these outcomes. The plan included pressure ulcers being discussed regularly at team meetings and the communication that this was the responsibility of all staff.

The endoscopy service was accredited by the Joint Advisory Group on GI Endoscopy (JAG).

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to told us they had received an induction and that they felt competent for their roles.

Managers mostly supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke to had received an appraisal or knew when their next one would be completed. The trust reported that 86.75% of staff across the medicines specialities at the Alexandra Hospital had received their appraisal. This included medical, nursing and administrative staff only. On average, 97.32% of specialty medicine medical staff who were eligible for an appraisal had had 1 in the past year. For Consultants, this figure was 100%.

The clinical educators supported the learning and development needs of staff. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Wards had a daily huddle where key information and training needs could be discussed with staff. Staff we spoke to explained the trust preceptorship scheme and spoke positively about the support they had been given.

Staff we spoke to told us managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers identified poor staff performance promptly and supported staff to improve. Managers recruited, trained and supported volunteers to support patients in the service. All volunteers attend an induction with the Volunteer Manager to explain and explore roles and training expectations. All volunteers are expected to undertake E-Learning for core

training modules and these are either undertaken independently or with staff team support (individually assessed). There is opportunity to undertake additional modules if individual volunteers would like to extend their awareness and learning. Some of the current Volunteer roles included but were not limited to; Way finder support for patients, Ward and Emergency department volunteers.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff had access to the physiotherapy team, occupational therapy teams and dementia leads. Meetings to discuss the needs of patients were held with supporting teams. Staff from other disciplines attended daily ward huddles.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff gave examples of working with social services teams, external pharmacies and adult social care to support the needs of patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

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

Mostly staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, we saw that the staff on the Discharge Lounge had difficulty at times obtaining medical support.

Although Endoscopy was not a fully staffed service 24 hours a day, there was an on-call system.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw during the ward rounds we attended that the needs of each patient were discussed whether these were dietary, social or physical.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Medical care (including older people's care)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke to demonstrated a good knowledge of how to assess patients and that enhanced observation charts were used where needed for a patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff were able to explain the consent process to us and explain the trust policy.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Most staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, the completion rate for this training was low, medical staff having completed 45.75% and nursing and clinical staff completion rate of 81.5%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke to told us they could access the relevant documentation and procedures and would escalate any concerns to the relevant clinical lead.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff interacting with patients in a caring and compassionate way.

Medical care (including older people's care)

Patients said staff treated them well and with kindness. Patients we spoke with said staff were polite and responsive to requests for support or care. Patients gave us examples of being supported emotionally by staff. On all the wards we visited we saw thank you cards displayed from patients. Patients told us they knew how to raise any concerns they had about their care.

Staff followed policy to keep patient care and treatment confidential. Patients we spoke to said they felt their privacy and dignity had been maintained. On the wards we visited we did not see any patient information on display and patient discussions were held away from bed bays.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. One patient explained to us that staff had supported them when they had been emotional and had been respectful. Patients told us they felt safe on the wards.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service had a social media based charity for clothing donations that could be accessed for patients in need prior to being discharged.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients told us they had been involved in their care and it had been explained to them. They also said they regularly saw a consultant and felt they could ask questions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Friends and Family survey results for October 2022 were positive. The responses ranged from 93.23% to 100% of patients who would recommend the service to friends and family.

Staff supported patients to make advanced decisions about their care. Patients gave positive feedback about the service.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement 

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

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, the discharge lounge did not always meet peoples needs. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The Endoscopy unit had no waiting list and the service planned well for patient flow.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service provided separate male and female wards.

Mostly facilities and premises were appropriate for the services being delivered. However, the discharge lounge was operating as a ward at times and staff reported that they felt these facilities were not always suitable for the patients needs. Between May 2022 and September 2022, the average length of stay in the discharge lounge was 15 hours, in October and November the average length of stay had increased to 25.45 hours.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff we spoke to told us these teams were responsive to requests for support for patients.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had good links with the local authority social service teams and staff were able to give examples of referrals to these services and the positive outcomes for patients and their families.

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. We saw assessments were completed for patients over the age of 65 to assess their needs for any additional support such as referrals to the dementia team or the learning disabilities team. However, staff on the discharge unit told us they could not always provide one to one care for patients living with dementia.

Staff were able to demonstrate a good knowledge of the needs of patients living with dementia and the support needed for the patients family. There was access to a Dementia Team who staff told us were responsive to requests for support or advice.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The service had information leaflets available in languages spoken by the patients and local community. Staff were able to request a translator if they knew in advance this would be needed for a patient alternatively, they could access translation service via a telephone service and could print information in other languages.

Access and flow

People could generally access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were generally in line with national standards. Discharges at times were delayed.

The latest referral to treatment data from November 2022 showed that the proportion of patients within the medicine specialities in the trust treated as inpatients within 18 weeks of referral was on par with the national average. The proportion of patients treated as outpatients within 18 weeks in the trust was slightly lower than the national average, at 64% versus the national average of 68.9%.

Waiting times for Endoscopy were roughly in line with the national average. In November 2022, 40.6% of patients waited more than 6 weeks for their procedure versus the national average of 37.9%. Fewer patients in the trust waited more than 13 weeks for endoscopy however versus the national average.

We reviewed cancer waiting times in the trust against the national target of 93% of patients seeing a specialist within 2 weeks of an urgent GP referral. In November 2022 75.6% of patients saw a specialist within this timeframe, significantly below the national target, and below the Midlands average of 82.6%. The trust performed better than the Midlands average in the proportion of patients treated within 31 days of a decision to treat however, at 93.2% versus the Midlands average of 87.2%. The national target was 96%.

The 'Continuous Flow Model' has not been instigated at the Alexandra Hospital, due to the nature and layout of the wards. The Flow model at the Alexandra Hospital works on the basis that all patients within Medicine go from the Emergency Department and are transferred to Acute Medical Unit (AMU) or Medical Short Stay Unit (MSSU). After patients have been reviewed, they are then moved directly to the medical wards. This could result in patients going to a variety of departments before being admitted to a ward.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service used a patient flow bundle called SAFER and the five elements are:

S – Senior review. All patients have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mind-set.

Medical care (including older people's care)

Patients who were deemed medically fit for discharge could be moved onto discharge lounge, however patients staying on the discharge lounge had increased from an average of 15 hours to 25 hours in the previous 6 months. Patients often waited longer than necessary to be discharged, the main barriers to a timely discharge were capacity in care homes in the community, patients waiting for electronic discharge summaries which had not yet been completed by doctors, and for tablets to take out, to be dispensed.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. This was discussed during Capacity and Flow meetings.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Most patients we spoke to said that the complaints procedure had been explained to them.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke to told us that complaints were shared with the clinical teams for learning and improvement. We saw a sample of ten complaints from patients. These complaints had been investigated and themes identified.

Managers shared feedback from complaints with staff and learning was used to improve the service. The evidence we saw showed the actions to be taken following a complaint such as to be discussed at team meeting and staff updated or to ensure improved communication with family members.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders generally had the skills and abilities to run the service. They mostly understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

The medicine service was 1 of 4 services overseen by the trust board. Medicine was divided into the Urgent Care and Specialty Medicine divisions, and each division was overseen by a Divisional Director of Operations, Divisional Director of Nursing and Divisional Director.

Medical care (including older people's care)

Staff told us that for the most part the senior leadership team were visible, and they attended the division on a monthly basis. The medicine division was split into the urgent care and speciality services which were managed by the trust board and the discharge lounge managed by the clinical site manager who was based at the Worcester Royal Hospital site. Some staff reported that they felt the leadership team was very visible. However, some staff told us they felt they were not included in key conversations about the running of the service.

The discharge lounge had previously been managed by the matron on the urgent care team and staff reported that they had felt this relationship had worked well and the matron was onsite and could be contacted easily. The change of management structure to the Clinical Site Team management had impacted the support the staff on the discharge lounge felt they received and had made communication less effective. Staff on the discharge lounge did not always feel supported as they had raised concerns and felt that leaders did not always have oversight of the situation. However, since our inspection management of the Discharge Lounges had moved to the Speciality Medicine Division. A Directorate Manager and Matron had been allocated to oversee the operational and quality and safety management of the Discharge Lounges.

Although Endoscopy came under the Specialised Clinical Services Division, we inspected this service as part of our medical care methodology and therefore have included this in our report.

Ward managers and matrons, we spoke to during our inspection demonstrated good organisational skills, a thorough understanding of the needs of the service, patients and staff. All staff spoke highly of the medicine teams and their local leaders.

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.

The trust had the '4ward' vision and strategy. The vision was "working in partnership to provide the best healthcare for our communities, leading and supporting our teams to move 4ward". Their strategic objectives were;

- Best services for local people
- Best experience of care and outcomes for our patients
- Best use of resources
- Best use of people

Their enabling strategies were clearly presented and consisted of Quality Improvement, People and Culture, Estates, Digital, Medium Term Financial Plan and Communications.

The trust promoted 4 '4ward' signature behaviours in staff which were;

- Do what we say we'll do
- No delays, every day
- We listen, we learn, we lead
- Work together, celebrate together

The staff we spoke to about the trust's vision and strategy were aware of it and knew where to access more information about it. The Trust had a group of over 300 staff '4ward advocates'. The aim of the group was to support and embed the '4ward' signature behaviours and provide 'ward to board' feedback from their colleagues to the Executive Team and Board.

Culture

Most staff felt respected, supported and valued and they were focused on the needs of patients receiving care. However, some staff explained that changes in management in some areas had not been positive and that they had felt unsupported and that they were not listened too.

The service promoted equality and diversity in daily work and provided opportunities for career development. Band 3 nurses we spoke to told us they had been given opportunities to extend their skills and professional development and had more training opportunities.

The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there were annual awards given for staff who had 'gone the extra mile'. Staff told us they enjoyed their roles and working in the team and that they supported each other in their day to day work.

During our visit we were told the service was holding a Health Care Assistants appreciation day, there were refreshments and gifts for staff and they could attend one of the meeting rooms to celebrate their achievements.

On staff notice boards there were displays with details of mental health support for staff and communicating equality and diversity groups. The service had a Freedom to Speak Guardian who staff could contact for support or to raise concerns, staff we spoke to said they would feel confident to raise concerns.

The service completed yearly staff surveys; the results are across the medicine speciality for both trust sites. More than 500 members of staff responded to the survey. The service scored highest at 7.3 out of 10 for the question if staff felt the 'service was compassionate and inclusive' and lowest at 5.8 out of 10 for the questions 'we are healthy', 'we are always learning' and 'morale'.

Patients we spoke to said they would feel able to discuss any concerns or complaints they might have and knew the process for raising complaints. There were signs on wards explaining how to make a complaint.

Governance

Leaders generally operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

Generally, the service performed well for governance processes such as meetings and feedback from audits and quality improvement processes. Weekly Divisional Governance meetings reviewed performance, audits, incidents and complaints.

Some staff said they felt leaders did not have oversight of the discharge lounge and were not always responsive to concerns they raised about safety or processes.

The service held regular staff meetings and information was circulated at these meetings, minutes were available for staff who were unable to attend. Some senior nursing staff reported that they were no longer invited to some of the governance meetings due to an organisational change and that this impacted on their ability to report or discuss concerns.

Senior staff attended meetings for their speciality and minutes from these meetings showed they were effective and well attended.

Management of risk, issues and performance

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

The service had a register for the monitoring and oversight of risks to the medicine division such as staff sickness or staff vacancies but did not always appear to have oversight of the risks for patients in the discharge lounge. The main risks were due to staffing on the discharge lounge and the lack of dedicated medical support. Also, some staff told us of instances where patients had been moved to the discharge lounge but did not meet the criteria for the standard operation procedure (SOP) for the discharge lounge and would be sent back to the main ward. In recent months patients were staying on the discharge lounge for an average of 25 hours and staff had raised concerns about the facilities, lack of medical support and lack of pharmacy support.

Management of medicines was not always robust, the service did not always use systems and processes to prescribe and administer medicines safely. Staff did not always follow systems and processes when safely prescribing, administering and recording medicines. Medicines were not always stored safely or appropriately to reduce the risk of errors. However, once we raised our concerns, we were told that pharmacy staff would review and provide support.

The service had a programme of local audits which monitored performance and actions arising from audits had been taken. We saw evidence of action taken following an increase in C.Diff infections on 2 wards and educational tools developed for staff to use to improve patient outcomes from these infections.

Information Management

The service collected reliable data and analysed it. Staff could generally find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could access patient notes in paper format and on an electronic system. Notes we reviewed were generally of a good standard and comprehensive. However, some staff we spoke to informed us of instances where paper notes used for transfer between wards had not been accurate.

Staff we spoke to told us they were able to access the procedures they needed for supporting their roles and that these were up to date.

Staff could report incidents using a reliable electronic system which the service could access for monitoring incidents.

The service reported incidents and safety alerts to external bodies in an effective way.

Medical care (including older people's care)

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There were monthly opportunities for staff to meet the trust Chief Executive in an open and informal forum. Staff could also ask questions and make suggestions via a social media account.

The service engaged with patients via a patient forum and wards displayed suggestions and comments made by patients and the action taken. Patients could also give feedback by a paper based questionnaire or an online account.

We saw minutes from the Strategy Leadership Summit event which took place on the 9 November 2022 and was attended by internal Trust staff as well as partners from the local ICB, Integrated Community Services , local Healthwatch, Public Patient Forum, local County Council, and other stakeholders.

The trust told us the aim of the event was to get together in person, to look for opportunities to improve. This included discussing the 3-year plan and understanding how and plan for the challenges to 2025 and beyond.

Learning, continuous improvement and innovation

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

The service communicated a ‘lessons of the week’ which arose from governance meetings and explored lessons learned from incidents.

The service completed quality improvements projects following C-Diff outbreaks on 2 wards and they had completed antibiotic medicine reviews. This had led to the trust ‘D.I.S.S the DIFF’ campaign which explained the complications of C.diff and the signs and symptoms. The campaign provided actions to be taken if it is suspected a patient has C-Diff and a new assessment tool for staff to use had been introduced.

The trust had the Path to Platinum quality improvement programme in place, where wards worked through 4 levels of accreditation, Bronze, Silver, Gold and Platinum. Results of the Nursing Quality audit fed into the programme. The trust had dedicated teams to support staff in quality improvement, including a Quality Improvement Matron.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training and this training was comprehensive and met the needs of the patients and staff. Training completion figures were 90.7%; this was above the trust target of 90%. Training data was discussed in the monthly governance meeting and team meetings.

Nursing managers told us they addressed any gaps in training compliance by prompting staff to complete the training within a specified time frame. The department had employed 2 practice development nurses whose focus was around education and training. They monitored the training and alerted staff when they needed to update their training. The staff were responsible for updating and booking onto their training themselves. All staff were given 12 hours annually to complete their e-learning training. Staff either chose to do this at home or within the department.

All staff had to be compliant with different levels of life support training depending on their banding or level. Healthcare assistants needed basic life support training; 90.91% had completed this. Band 5 staff nurses needed Immediate Life Support (ILS) and Paediatric Immediate Life Support (PILS) Training. They could not attend ILS or PILS until they had been in the department for 6 months unless they had come from another emergency department (ED). They had had 11 new starters within the last few months out of their 43 staff members. This meant that the figures were low at 70% for ILS and 74% for PILS. All senior nursing staff had to complete European Paediatric Advance Life Support (EPLS) and Advanced Life Support (ALS). They were 79% complaint for EPLS and 100% compliant for ALS. We were told that there were only 2 courses of EPLS a year therefore it was hard to maintain compliance. We saw that the next available course was in March 2023. The manager in charge of the rota said that they had assigned skills to each staff member within the roster. This meant that when they were completing the staffing rota, they were able to ensure that during each shift there was someone who was EPALS and ALS trained.

Medical staff did not always receive and keep up to date with their mandatory training. Medical staff training showed an overall mandatory training compliance rate of 52.27%. The trust informed us that there would be a focus on mandatory training for medical staff and hoped for this to be increased by 20% by the end of December 2022.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff could access support from specialist teams and nursing staff when needed.

Urgent and emergency services

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all staff were updated with the relevant training.

Nursing 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 86.49% for safeguarding adults level 2 and 92.85% for safeguarding children level 3. All band 7's and above needed safeguarding level 3; they were 44% compliant. The trust target was 90%. We saw there was evidence of staff booked onto courses where compliance did not meet the trust target. All staff we spoke with said they had received safeguarding training at a level appropriate to their role. Most nurses were trained to level 2 adult safeguarding and level 3 children safeguarding. This was in line with national guidance for nursing staff in EDs.

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.

Children identified as being at risk while in the ED were referred to the trust safeguarding team and to the local authority appropriately. There was a system to flag up known concerns about children and families.

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 in the local NHS trust providing community mental health services as required. Staff reported that they were very supportive and easy to access. There was a pathway to follow for paediatric patients who presented with mental health conditions.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

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

All areas within the ED were visibly clean and had suitable furnishings which were mostly well maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Furnishings, such as chairs and flooring were wipeable and easy to clean. There were sufficient quantities of personal protective equipment (PPE) available for staff to equip themselves for the different levels of protection required within the department. Staff mostly 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 number of staff who did not wear the surgical masks properly and had their noses exposed and one staff nurse was wearing nail varnish. Staff wore disposable gloves and aprons, when required, for example when assisting patients with personal care.

Managers audited staff compliance with infection control practices including hand hygiene, use of PPE and cleaning. Hand hygiene audit results were 100% for June to August 2022. Compliance was reported to the governance team. Staff were not always aware of the audit results. Managers said that poor compliance would be addressed in handovers and team meetings. Audit results showed staff were following infection prevention and control guidance and that the ED environment was kept clean and tidy. The local cleaning audit was 95% for August to October 2022.

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 97%. Equipment not in use was stored cleanly. We saw 2 sharps bins stored on the floor; this was escalated at the time of inspection. The department had regular cleaners however, they did not work at night and the managers felt that this was needed. They had asked for further funding to employ a cleaner at night as they were not seeing a dip in patient activity overnight.

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 95.18% of staff had completed infection control level 2 training. The practice development nurses reminded staff if their training needed completing.

The staff could get further IPC information from the link nurses within the department or 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 2022. 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 was a designated 5 bedded area for patients who presented with COVID-19 symptoms or had tested positive for COVID-19. They were then admitted to a specific COVID-19 ward. All patients were asked screening questions on arrival to ED. We saw this was completed in 16 out of the 18 notes we looked at. There was a policy for staff to test themselves if they had symptoms of COVID-19.

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 mostly followed national guidance. All areas in the department were suitable for their purpose and mainly clutter free. However, patients were being cared for within the corridor. The service had 22 beds across majors, early decisions unit (EDU) and resuscitation areas; this included 2 high visibility cubicles and 3 paediatric cubicles. The paediatric cubicles were mainly used for adult patients since the service saw a reduced number of paediatric patients within the department; about 8% of their attendances were paediatric patients. ED were also able to safely have up to 7 patients in the corridor, but this was mostly kept to 5. Whilst the ED had ensured that call bells were in place for these patients, there was a lack of space within the corridor and it was not a suitable environment for patients to be for long periods of time. We were told that patients were regularly staying on trolleys in the corridor for prolonged periods of time. We saw 4 patients who were nursed in the corridor overnight; all were discharged the

following morning after their treatment. The corridor was close to the nursing station and all patients could be easily seen; therefore, it was often used for patients who needed to be visible to the nurses at all times. There was a nurse who was assigned to look after the corridor patients throughout each shift. There was a standard operating procedure which detailed a criteria for patients who could and could not be cared for on the corridor.

Scheduled monthly fire evacuation route audits monitored all evacuation routes for changes to protection and risk levels and any necessary remedial work or mitigations were sent to local managers for immediate action.

The service also had a Rapid Assessment Triage (RAT) area and a 'Fit to Sit' area. The RAT had 2 trolley spaces and was used to assess and triage patients who were brought in by ambulance. These patients were then moved to an appropriate area within the department. The 'Fit to Sit' was an ambulatory area with 3 cubicles; 2 had one trolley in and the third had 4 large recliner chairs separated by a screen. These areas were not designed for overnight use. We were told that patients stayed in the reclining chairs for excessive periods of time and overnight if necessary. We spoke to 2 patients on the 23 November 2022 in the afternoon. They reported they had slept in the chairs overnight. One had asked for a cushion for their bottom and had received this. Both appeared to be in high spirits and accepted that the hospital was busy, so they were cared for in chairs until a bed became available on a ward. Patients were on different treatments while in the room, including intravenous (IV) therapies and nebulisers. There was also a dedicated chest pain cubicle. This was to ensure that patients with chest pain were seen quickly. There was a standard operating procedure (SOP) for the use of this room which contained admissions criteria for patients allocated here. For example, patients who had a National Early Warning Score (NEWS2) of above 5 were unable to be admitted to 'Fit to Sit'.

There was an EDU which was being used as a respiratory area for patients who had symptoms for COVID-19. There were 5 beds which were separated by walls; we were told that there had not been a COVID-19 outbreak in this area. There were 3 cardiac monitors within this area, a separate sluice and emergency equipment. There was a strict admissions criteria for this unit. No children could be admitted into this area and no COVID-19 negative patients.

The resuscitation area had 3 beds; 2 had defibrillators within the bed space. All equipment was checked on a daily basis and tagged and then a full check was done monthly. There was a visual board which had an aerial view of the cubicles and clearly pointed out where equipment was for people who did not work regularly within the department.

There were insufficient treatment and assessment areas to accommodate all the patients attending the department. Patients were frequently held on the back of ambulances until space in the department became available. These patients were assessed by a Global Risk Assessment Tool (GRAT) nurse whilst waiting on the ambulance. They assessed their concerns and rated their need for admission to the department using a red, amber, green (RAG) rating system. When we were in the department, there were 6 ambulances waiting outside with another on route and the longest wait for admission from the ambulance was 4 hours.

Walk in patients were booked in at the main reception area. There were several reception staff on duty day and night. Patients queued prior to presentation at the reception desk. After booking in, patients saw the triage nurse and were asked more details about their condition and they were graded according to the severity of their presenting complaint.

Patients who attended with suspected minor injuries were sent to the minors area which was located off the main waiting area. This was staffed by 2 emergency nurse practitioners (ENPs) between 8am till midnight and GPs between 8am and 6pm. There were 4 rooms including an eye room and plaster room. The ENPs looked at the patients within the waiting room and the triage information and selected patients who were suitable.

Urgent and emergency services

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. 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 on most days. All staff were given a medical devices booklet that needed to be completed which was accompanied with online training.

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 mental health room had 2 doors, 1 opened to the main corridor and 1 opened onto the EDU. The room had no ligature points and 2 alarms. There were glass viewing panels, the room was well lit. There were chairs that were easy to clean, they were solid and heavy but moveable, this was raised with the senior sister on the inspection. The room was clean and tidy.

The service's facilities were in need of an upgrade in order to meet the needs of patients' families. The relatives room was basic with a couch and window in the room. There was a ligature point in this room which was pointed out to the senior sister at the time of inspection. There was no information for the relatives within the room. We were told that the well-being lead was hoping to refurbish the room to make it a more comfortable environment for relatives.

Assessing and responding to patient risk

There were delays in moving patients off ambulances into the ED and in triage when the department was full. This resulted in delays in assessment and treatment for some patients. Patients admitted to the department had some of their risks assessed and updated.

Staff did not always complete risk assessments for each patient on arrival, using a recognised tool, in a timely way. Patients who arrived by ambulance, when the ambulance assessment area was full, 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. Between 7 August and 27 November 2022, on average, 15% of ambulances were taking between 30 and 60 minutes to handover, which was in line with national average, and 21.5% of ambulances were taking over 60 minutes to handover. This was worse than the national average of 12.1%. These patients were triaged by a GRAT nurse who then rated their order of clinical emergency using a RAG rating. 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 patients were monitored regularly by ambulance staff and the GRAT nurse. The GRAT nurse had received further training to complete this role. Medical staff did not routinely assess patients whilst on the ambulance, however, if the patient was deteriorating and there was no bed available, they would review the patient and start any treatment where possible. We were told that treatment was not generally done on the ambulances by the ED staff as this was difficult to monitor.

The GRAT completion compliance was reviewed for 10% of the patients on a weekly basis. If a GRAT was not completed, then they would look to see if there was an incident report which indicated if any harm was caused as a result of the delay and any harm identified would be escalated. The patients discharge outcome is also assessed. We saw data for the week ending 20 November 2022 which was for both ED's across the trust. There were 5 delays analysed for Alexandra Hospital ED and 1 out of 5 was found to have no GRAT form; they waited over 173 minutes on the ambulance before they were handed over. However, there was no harm for the patient and they were discharged the same day.

Urgent and emergency services

We saw that, at times, ambulances were waiting for long periods of time to handover. For example, on the 28 November 2022, the average handover time for the ambulances was 2 hours 18 minutes, with the longest delay recorded as 5 hours 31 minutes; only 32.6% of handovers were completed within 30 minutes of arriving into the department.

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. Data showed that between 7 August and 27 November 2022, 24.3% of patients were treated within 60 minutes of arrival; this was below the England average which was 32.7%. We saw this whilst on inspection. For example, on 22 November 2022, a patient came into the department at 20.07pm and was triaged at 21.51pm. If there was a high footfall into the department there would be a second nurse to assist with triage. We saw at the band 7 team meeting in November, that delays in triage were discussed. The managers were developing a SOP with the ENPs for streaming and assisting the triage nurse. Senior staff reduced the risks associated with delays to triage by allocating experienced nurses working in triage. All nurses who worked in triage had completed triage training. This helped identify the sickest patients, or those most at risk of rapid deterioration, as soon as possible.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, delays to triage could mean that escalation was not always timely. Adult patients were assessed using the 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' (2017). 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.

Patient observations were recorded and RAG rated electronically in triage and then subsequently on paper. The electronic triage calculated the NEWS2 and set frequency of observations and any escalation response. The NEWS2 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. The service audited NEWS2 and results from August to October 2022 were above 97%.

The NEWS2 scoring was a paper based system which meant that the nurse in charge and doctors did not have oversight of potentially deteriorating patients within the department. Nurses had to manually put a message next to the patient's name on the computer system if the patient had an increased NEWS2. The nurses verbally informed doctors if a patient had a deteriorating NEWS2. There was no automatic alert. However, we were told that electronic patient records were being introduced in November 2023. This meant that NEWS2 would be recorded electronically, and all staff could see up-to-date NEWS2 scores for all patients within the department.

Staff knew about and mostly dealt with any specific risk issues. The service had recorded 31 falls since April 2022 with no harm caused. Managers told us that they had changed the process in the department and all patients who were admitted were screened for their risk of falls. This was following an incident where a patient fell in the department, prior to April 2022, and subsequently died. We saw on the October 2022 matrons assurance report that an increase in falls had been highlighted due to overcrowding and increased length of stay in the department. There was to be a new falls training session rolled out within the department.

Urgent and emergency services

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. Between 14 and 27 November 2022 there were 16 patients referred to the mental health liaison team; 43.8% were seen within 30 minutes. The average wait to be seen was 93 minutes.

The department had ENPs who worked between 8pm and 10pm Monday to Thursday and 8am until 12am from Friday until Sunday. They supported the ED doctors to review patients.

There was an alcohol liaison nurse who attended the department daily and was available from Monday to Friday 8am till 4pm. The nurse provided support to the ED team regarding alcohol related issues and assisted with managing the pathways through the hospital.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers did not always include all necessary key information to keep patients safe. We observed a handover huddle which included information about waiting times and staffing levels. The nurse in charge reminded staff to complete hourly checklists and discussed a patient confidentiality incident. All nurses handed over their patients individually to the staff. They did not discuss all of the patients within the department. This meant that the nurses did not have oversight of all potential patients at risk within the department.
There is a 4-hour emergency care standard from the RCEM which states that patients should spend less than 4 hours within the department. There were delays in the department throughout July to November 2022 with only 48.6% of patients spending less than 4 hours in the department for this period of time. The England average over this time period was 70.3%. Only 24.2% of patients were treated within 60 minutes of arrival; the England average for this was 33.1% in the same time period.

The department had moved primary paediatric services to the Worcestershire Royal Hospital. However, they did still see walk-ins. Between 7 August and 27 November 2022, 9.9% of attendances to the department were children. There were no paediatric trained nurses in the department. However, all staff were required to complete the Royal College of Nursing competencies for emergency medicine; 65% of staff had completed the paediatric competencies. The rest were working their way through them and some were near completion. There had been a large number of new starters, including overseas nurses, within the last 12 months and support was being given to ensure they had good understanding of competencies prior to being signed off. The trust had set a target to complete all competencies by January 2023. We were not reassured that all staff looking after children were up to date with their training. Staff were required to do PILS or PALS depending on their seniority. The manager who completed the staffing rota ensured that there was always a member of staff who had completed PALS on shift and with the correct skills to stabilise and transfer a child to the Worcester Royal Hospital when required. The managers had arranged for a team from the local children's hospital to do practice emergency scenarios for staff. These were filmed and then they watched them back for learning. All staff were required to complete a shift on the trust's paediatric ward every 6 months; compliance to this was 68%.

Sepsis treatment and recognition was audited in ED. Results from July 2022 showed that 70 patients were audited for sepsis. Of these, 58 patients were found to be septic and 66% (38) received antibiotics within 1 hour; 43% (25) did not receive 1 or more elements of the sepsis 6 bundle within an hour. This was similar to the monthly compliance in August and September 2022. We saw an action plan was in place to improve compliance. However, some actions did not have updates so we were not assured that there was good progress with this action plan. We found that nurses and medical staff were aware of recognising sepsis and we saw no delays to treatment for suspected sepsis patients during our inspection.

Each computer in the department had access to a patient management screen which displayed an overview of patients in the ED. It showed the length of time each patient had been in the department, or on an ambulance, or were waiting for triage, or treatment. Managers saw where the greatest risks were and moved staff and resources around accordingly. Senior trust staff outside of the ED had access to the screen and viewed live information. A bed flow manager was based in the department every day and liaised with site managers, matrons and doctors to access beds for patients as soon as possible. Risks were discussed at regular bed meetings every day. This included capacity in the department and the hospital. There was good oversight of daily issues by the senior ED team.

Staff had access to a psychiatric liaison service 7 days a week from 8am to 6pm and 8am to 4pm at weekends. Out of hours the staff would contact the crisis team. Both teams were provided from the local NHS community trust that provided mental health services

We saw that the guidelines and pathways for illnesses, such as diabetic ketoacidosis and sepsis, were available on the trust's intranet, were appropriate and in use. There were protocols in use for emergency situations, such as trauma, cardiac arrest and massive haemorrhage which would be attended by specialist teams.

There were easy to use antibiotic guidelines and there was a guideline for patients with suspected neutropenic sepsis. The department completed antimicrobial stewardship (AMS) audits and had a compliance of 75% submission over the last 12 months. There was an action plan in place, however, not all actions were completed, and some were abandoned, due to the AMS pharmacist leaving the trust.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, there was no paediatric nurse on site.

The service had enough nursing and support staff to keep patients safe. Managers regularly reviewed staffing levels and skill mix to keep patients safe**.** Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The number of nurses and healthcare assistants matched the planned numbers. Nurse staffing in the ED had been established as 13 nurses and 2 healthcare assistants per shift. The manager in charge of the rota had assigned skills to each staff member so that they could schedule staff based on their skills to ensure that the department was always safe. They always made sure that there was someone on shift who had EPLS, triage training, nurse in charge training and ALS. Data showed that 100% of senior staff were trained in ALS and 79% had EPLS training.

There was no paediatric nurse on site. The service saw on average 15 paediatric patients a day, and the majority of these were minor injuries. The 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012) recommends that EDs should have a minimum of 2 paediatric trained nurses per shift. The department had ensured that the nurses had completed children's nursing competencies including recognition of the sick or injured child, paediatric life support skills, and completed practice scenarios to ensure that they had the ability to initiate appropriate treatment. There was a SOP in place which detailed caring for paediatrics within the department. All paediatric admissions were transferred to an appropriate paediatric facility. Staff have immediate access to telephone or telemedicine support from consultant paediatrics based at Worcestershire Royal Hospital (WRH). However, they did not try to reduce the number of paediatric attendees to the department. We did not see signage which stated that it was not a dedicated paediatric department. For example, the trust website states, "The Alexandra Hospital will continue to see and treat children with minor

ailments and minor injuries and who do not need an overnight stay." This meant that paediatrics were not discouraged to attend and often they were sick and required admission. This meant a transfer to another hospital. The trust responded to us following the inspection to state that they would put signage in the waiting room to advise that seriously ill children are taken to WRH. They have also re-instated paediatric attendance on the ED risk register.

The service had high vacancy rates. The nurse vacancy rate was 18.09%; the trust target was 7%. In August 2022, the vacancy rate was 8.95% for nursing support staff, this had reduced to 0.28% by October 2022 following recruitment into the posts. Nurse staffing was on the service risk register and had been since March 2018. Senior nurses continually recruited nurses and had recently appointed a group from overseas and newly qualified nurses. The staffing gaps were covered by long-term agency staff. New nurses attended a trust induction and a local 4-week induction and training. They were given comprehensive competency booklets along with a full programme of mandatory training. Agency staff block booked shifts and were regular staff who knew the department and were experienced ED nurses. New bank and agency staff underwent a local induction in the department.

The service had sickness rates between August and October 2022 below 6%. The trust target was 3.5%. We were told that the main reason for sickness was non work-related stress or anxiety. The department had recently trained a well-being nurse. Staff told us that they were very supportive if they felt anxious and stressed and helped to reduce their anxieties.

The service had had high levels of agency nurses. Within the last 12 months, the service had an agency usage of around 40%. This had dropped to 30% at the end of October 2022. We saw that the fill rate for the shifts was always above 98%. Managers requested staff familiar with the service; they were all long-term agency staff who were block booked and knew the department. One agency staff member told us they had been in the department for 3 years and they had been given extra training paid for by the department.

The turnover rate for nursing staff was 12.68% in October 2022. This had improved form 14.92% in May 2022. Recruitment and retention was part of the 2019 urgent care strategy. Within the strategy it detailed developing rotational posts and clear career progression pathways. Leaders had a retention of staff incentive in place. There was a retention bonus if a staff nurse committed a further 18 months to the department after their first year. The leaders had recognised that they needed to develop the staff in order to retain them and had developed rotational leadership programmes and different in-house training. All staff said that the training was fantastic within the department. We spoke to a staff nurse who had left the department for a job within the community and had recently returned to the staff nurse role in ED as they missed the team, training and department.

Medical staffing

The service mostly 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. However, they did not always meet the Royal College of Emergency Medicine (RCEM) recommendations of 16 hours consultant presence every day. 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. There were 10 consultants within the department, 5 of them were full time and the other 5 split their time between the Alexandra Hospital and Worcestershire Royal Hospital. Consultants were in the ED 8am to 10pm every day with some days covered until midnight. This did not always meet the RCEM recommendation of 16 hours consultant presence every day. This was highlighted as a risk within their urgent care strategy (2019) that they had insufficient staffing to meet the RCEM guidelines. They proposed that by 2025, they would

have a fully integrated team with consultants for 16 hours a day 7 days a week. Consultants stayed longer in the department at night 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. We reviewed the rota for the week and all shifts were covered apart from 1.

Overnight the department was staffed by 3 doctors with a minimum of 1 senior. There were 2 advanced care practitioners (ACP) who assisted the medical staff with reviewing the patients. There were no physician associates (PA) within the department, but they did host PA students and had discussed potential future PA recruitment. Every shift had a senior doctor who had advanced paediatric life support and advanced trauma life support.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had high rates of bank and locum staff. By October 2022, they had used 973 hours of locum usage within the last 6 months. Most of these hours were for speciality doctors, consultants and speciality and associate specialists (SAS). They used reliable regular locum staff who provided a good quality of locum cover. We were told only occasionally non-regular locums were required and they were not left in charge of the department.

The junior doctors had training every week for 2 hours. We were told this was poorly attended as locum staff were not permitted to attend and due to a high prevalence of locum staff, this meant only 1 or 2 attendees. 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 both told us that they had access to senior staff when they needed advice, including out of hours.

There was a GP service that ran from 8am to 6pm every day. This was either delivered by a GP or an ACP. The referral process was triage nurse dependent and there was a criterion for these patients to be seen by the GP. Whilst this service was established to provide ED attendance with primary care needs, the clinicians did not have access to GP computer systems and therefore could not access pathways available to GP's for example, 2-week wait. This meant that patients either required an ED assessment with additional investigations or signposting back to the GP for onward referrals. One locum GP had recently approached the manager to ask for a permanent role as they enjoyed working within the department.

The service had high but reducing vacancy rates for medical staff. There was a 20% vacancy rate, but this had reduced from 39.66% in May 2022. The vacancy rate for Consultant posts was 0% but was 65% for staff grade doctors. The turnover rate was 0% over the last 12 months. We saw in the senior leadership team meeting minutes from September 2022 that consultant interviews had been held in August 2022 and 1 had been appointed to commence in December and interviews were being arranged for speciality doctors.

Sickness rates for medical staff were low. The sickness rate for the last 3 months was below 2.5%. There were no medical staff off on long term sick at the time of our inspection.

Records

Staff kept detailed records of patients' care and treatment. Records were not always clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were not always completed. We looked at 18 records and found that hourly checklists were poorly completed. There was an hourly checklist that prompted staff to look at patients' pain, hydration, and other basic needs. We found that 11 out of 18 of these were not completed hourly, and 6 of these were not completed at all. Staff

told us that these had been recently introduced and were a struggle to complete hourly with the other pressures within the department. These care rounds were audited by the department on a twice weekly basis and this was 100% each week from September to October 2022 apart from 18 September 2022 when it was 93.33%. However, the senior nurses did say they had noticed that it was being poorly completed and had encouraged staff to complete within handovers. The checklist was being updated to make it easier to complete in a more timely manner.

The service audited their medical records weekly. Results from September to November 2022 show good compliance with completion of documentation. Most areas were 100%. The areas that were not always 100% completed were property lists and COVID-19 screening.

All staff could access notes easily, however, they were not always stored securely. There were many areas in which the notes could be kept, and this led to confusion. Notes for patients who received care in the corridors were left on the nurse's station and other notes were left in patient trolleys. We saw several occasions where notes were misplaced, and the staff were looking for them.

The service used a paper-based system alongside an electronic triage system. The triage nurse saw the patient and completed their observations and screened them on the computer which generated an urgency level for the patient to be seen. Following this, all patients' records were on paper. This meant that there was a lack of continuity and there was a chance patient deterioration such as an increase in NEWS2 could be missed.

When patients transferred to a new team, there were no delays in staff accessing their records as they were all on paper and transferred with the team.

Medicines

Although staff followed systems and processes to safely prescribe, administer and record medicines it did not always meet the needs of the patients.

Prescribing of medicines with reasons including antibiotics and length of treatments were documented in patients notes and on all medicine charts seen.

Medicines supply from pharmacy were available and staff knew the routes to obtain medicines out of hours if required. However, of the 18 medicine charts reviewed 2 patients were not administered some of their prescribed medicines because they were not stocked or available in the ED. We were told that in order to obtain a non-stock medicine from pharmacy the patient's medicine chart was sent to pharmacy, which meant the medicine chart was not available. Sometimes a member of the ED staff had to leave the department to collect the medicines which could lead to delays in treating patients.

The introduction of an Electronic Prescribing and Medicine Administration (EPMA) system is due for implementation in May 2023 which will potentially help reduce this situation occurring.

Although staff reviewed each patient's medicines there was no clinical pharmacy service to support and provide advice to patients and carers about their medicines. Staff checked patients medicine requirements on their prescription chart prior to administration. However, there was no clinical pharmacy service within the emergency department to undertake reviews and clinical checks on prescribing or to provide medicine advice and support to staff, patients or carers.

Staff did not always complete medicines records accurately and keep them up to date. On 3 out of the 18 prescription records we looked at, we found medicines were not given, such as antibiotics and time critical medicines. We raised this with the nurse at the time of inspection. We also found that there were duplications with prescription charts. For example, when patients were clerked by the medicine team, they were written a prescription record; this was in addition to the ED prescription chart. This meant that there was a duplication of medicines and could cause overdose. We saw that an infusion was prescribed on 1 chart at 12.45am. It was then prescribed on the other chart regularly 3 times a day. This meant that if the nurse gave all of these prescribed infusions, the patient would have had more than their required dose in 24 hours. This was raised with the nurse in charge at the time of inspection. Following the inspection, the Trust informed us that they have included a review of prescription charts into their weekly nurse quality checks. This was also fed back to the governance team and medical staff to cascade to the medical team.

Documentation of when medicines were administered including routes of administration and specific times of administration were completed. Allergy statuses of patients were routinely recorded on all medicine records seen and a red wrist band was mostly worn by patients to identify the medicine causing the allergy. This meant that allergies were highlighted, and medicines could be prescribed safely. However, we did see 1 allergy band was still in the patients notes and not on the patient. We raised this with the nursing staff.

Weights of patients were recorded on medicine administration records which is important for calculating weight-based medicines prescribing. Venous thromboembolism (VTE) risk assessment outcomes and prescribing were completed on all patients notes reviewed at admission.

Staff did not always store and manage medicines securely or safely. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. However, there was poor organisation and storage of medicines in the 'clean utility' room and in resus. Medicine cupboards were over full which made it difficult to easily find and locate a medicine. In the 'clean utility' room, there were loose blister strips of medicines which were not stored in their original container. One blister strip had been cut in half and was no longer identifiable. This increased the potential risk of a medicine error or a medicine not being located. On raising this issue with pharmacy immediate action was taken to remove the loose strips of medicines. The trust have since told us that they are in the process of working with the Director of Pharmacy to allocate a Pharmacy Technician to support the medicines management within ED including the safe and secure handling of drugs. They have also added the storage of medicines onto the weekly nurse quality checks. The service audited the safe and secure handling medicines storage on an annual basis. The results for 2021 was 94% and audits for 2022 were still in progress.

Patient's own medicines were not always stored safely or securely. For example, a patient's own medicine was found in the patients notes trolley. We were told this was to ensure it would not get lost, however, this does not follow the trust medicine policy or ensure safe or secure storage of medicines.

Pharmacy will be increasing support to the ED in the new year 2023. This will include increased Assistant Technical Officer time with 3 medicine top ups a week and medicine stock list reviews.

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 7 CD incidents between April to June 2022. Controlled drugs were not audited

regularly due to limited pharmacy capacity. The most recent audit completed was between April and June 2022 and it was 74% compliant. The service did not send the audit or an action plan associated with this. Therefore, we were not assured that improvements were being made. The trust had set up a safe medicines practice group which held its first meeting on 28 February 2023 and were targeting these actions.

Medicine fridges were locked and secure with authorised staff access only. Records of medicine fridge temperatures were recorded daily and were within a safe range for medicine storage. Room temperatures were taken but we found that when they were out of range, they were not always acted upon.

Prescription pads were stored securely, and records kept. This is seen as good and safe practice.

The department had patient group directives (PGD's) with a standard operating procedure. This allowed nurses to administer specified medicines to a pre-defined group of patients, without them having to be prescribed. The medicines that were under a PGD included medicines for a low blood glucose, basic pain relief and medicine to treat chest pain.

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 using the Summary Care Record (SCR) which is an electronic record of patient health information created from General Practice (GP) medical records. This information was recorded into all the patients notes we reviewed.

Staff learned from safety alerts and incidents to improve practice. A medicine link nurse provided a good link with pharmacy to help improve practice and share learning. The service had recorded 27 medication incidents since April 2022; 1 of these caused harm. 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.

The trust had a Medicines Safety Officer (MSO) in line with NHS England directives. The MSO investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents. Any learning was shared via newsletters or posters.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

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 investigation 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, we were told about an incident where a patient fell as their catheter bag was attached to the bed and resulted in a hip fracture. All staff were informed of this and advised to use catheter stands and leg bags.

The service had no never events in the department in 2022. 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.

Urgent and emergency services

A monthly matrons assurance report was produced which detailed the incidents over the month and looked at the top themes. For example, in October 2022, the top theme reported was tissue viability. This was high as staff reported all tissue damage as an incident on admission to the department.

Managers shared learning with their staff about incidents that happened elsewhere. For example, we saw a copy of the 'Worcestershire weekly' from September 2022 and the lesson of the week was how to prevent fires during emergency defibrillation. A spark had arisen under a chest pad of a patient which led to significant burns; the learning points including always shaving a patient's chest hair.

Staff met to discuss the feedback and look at improvements to patient care. Staff held monthly meetings with the managers and were given feedback about incidents and improvements needed. If there was a serious incident in the department, a team debrief would occur. Managers debriefed and supported staff after any serious incident. They did a 'hot' debrief immediately after an incident and then had a 'cold' debrief 1 to 2 weeks later. This gave the staff time to process how they felt about the incident. We were told that managers were very supportive following difficult incidents. There was a well-being champion who was trained to recognise signs of stress and anxiety. One healthcare assistant told us that they had had a difficult incident that day and the well-being champion had recognised that they were finding it hard and had supported them.

All staff always finished their shift together with a debrief in the seminar room. They discussed the shift and spoke about any incidents that might have occurred.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Clinicians completed a structured judgement review for all patient deaths within the service and produce a mortality report following the reviews. Deaths were also discussed at the Serious Incident Review and Learning Group (SIRLG). This was a multidisciplinary and cross-divisional governance meeting. If there were concerns about the care received, a comprehensive internal investigation was commissioned. We reviewed a mortality report from August 2022. They signposted staff to an article that was linked to a death for the staff to read to gain further learning. We reviewed a SIRLG investigation. We saw that a comprehensive review of the patient's care was conducted, and an action plan was put into place. We saw that the report was shared with the family as per the duty of candour.

Is the service effective?

Good ↑

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Urgent and emergency services

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service participated in clinical audits which enabled them to evidence care was being provided in line with national recommendations and best practice. They conducted sepsis and triage audits and mostly followed sepsis screening guidance.

The service did sepsis audits and mostly followed sepsis screening advice. We saw evidence of the sepsis pathway in use and it was utilised well. However, patients did not always receive their treatment within the 1-hour timeslot. There was good practice embedded for chest pain where the patients were seen within the 'fit to sit' area and had prompt investigations to diagnose the severity of their symptoms.

The hospital was not a stroke centre, but there was a stroke pathway in place as they did have patients who may walk into the department experiencing symptoms. They were able to provide rapid clinical assessment and CT scans with a potential of a blue light transfer to a stroke centre.

The service used the National Institute for Health and Care Excellence (NICE) guidelines to ensure that care was evidence based. The service used NICE implementation support tools such as Intravenous fluid therapy in adults in hospital clinical guidelines (CG174) 2017.

We discussed the Diabetic Ketoacidosis protocol with a foundation year 1 doctor who could explain the process well and it was in line with national guidelines.

There was a lead consultant for ensuring that policies and guidance were up to date. Other consultants confirmed that the latest guidance was always circulated and discussed.

Staff protected the rights of patients subject to the Mental Health Act 1983. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff mostly made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Healthcare assistants (HCA) ordered a selection of sandwiches to be kept in the fridge in the service's kitchen, but if there was an influx of patients, these could run out, or be mismatched to a patient's dietary needs. We spoke to a patient who was only offered a cheese sandwich and was told there was nothing else; they did not eat cheese therefore had no lunch. We escalated this to the staff who were able to source something for the patient to eat. We were told they could order more sandwiches if required. There was also hot food available at 5pm which was either soup or a jacket potato. HCAs did a breakfast round which offered cereal and toast to patients who had stayed overnight.

Staff did not always complete patients' fluid and nutrition charts where needed. We found that due to the environment, these were not regularly completed. Patients often stayed longer than 4 hours, but we did not see that the fluid balance charts were filled in, even when on intravenous fluids.

Most patients we spoke to had been offered food and drink. We were told that patients waiting on ambulances were offered refreshments when the waits were long.

Patients who suffered with dementia were given special food packs from catering which were more nutritious and contained fruit. They were also provided with dementia bibs if required. The dementia link nurse told us that they often distracted patients with television in order to get them to eat.

Patients who were vulnerable and lived on their own were given a going home pack. This contained soup, butter, bread and milk.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and mostly gave pain relief in line with individual needs and best practice. Patients pain was routinely monitored on the care and comfort rounds which was audited on a weekly basis. We saw that this mostly received 100%. However, we found this was often not completed. Staff did not always check pain and giving pain relief was inconsistent. We looked at 18 sets of notes and 7 of these showed that patient's pain was not regularly checked.

Staff prescribed, administered and recorded pain relief accurately. However, patients did not always receive pain relief soon after they requested it, or it was identified that they needed it. We saw evidence that in some cases, pain relief was given over an hour after it was prescribed. Staff did not always check the effectiveness of analgesia. One patient had come in following a road traffic accident at 9.12am and complained of pain everywhere, they were seen at 10.10am but not given any analgesia until 12.20pm. We also saw another example where a patient had a pain score of 8 out of 10 but was not given any analgesia for an hour. Their pain score only decreased to 6 out of 10 and 5 hours later, no analgesia had been given, despite the pain score being completed hourly at over 6 out of 10. We escalated this and the patient was given pain relief.

We were told that there was limited access to the pain management team. The department had recently had more controlled medicines added to their stock which meant they were able to manage chronic pain better.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and mostly achieved good outcomes for patients. However, data was not always submitted within the timeframe.

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. They completed the Royal College of Emergency Medicine audits on an annual basis. 'Pain in Children', 'Infection Prevention and Control' and 'Cycle Consultant sign off' data had just been collected therefore the results and analysis were not fully available. The Pain in Children audit showed that most children had their pain assessed within 10 minutes of arrival. However, there were issues with the data entry and compliance was below 50% for some standards. Mostly, outcomes for patients were positive, consistent and met expectations, such as national standards. For example, the fractured neck of femur 2021/22 audit showed that pain score was assessed in over 98% of patients within 15 minutes of arrival which is higher than the national average which was 74.51%. The infection control 2021/22 audit had mostly 100% compliance as they had comprehensive and robust policies in place. Audits were also completed as a result of learning from serious incidents, for example, a toxicology audit after a toxicology related patient incident.

The department participated in 'Better Outcomes for Patients Programme' (BOPP). This was a series of audits which are chosen by the directorate to look at specific aspects of care within the department. For example, 'Use of head injury proforma' and 'Management of Upper GI bleed'; the latter was brought in following a serious incident. In December, there is a BOPP workshop planned. The purpose of this workshop is for all divisions to set their BOPP audits for 2023-24 using the current data and feedback from incidents, complaints where change for quality improvement is required.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. Audit results were shared with staff on a monthly basis and discussed by the managers within governance meetings.

Managers used information from the audits to improve care and treatment.

The service had a lower than expected risk of re-attendance than the England average. Between May and November 2022, re-attendance within 7 days was between 6.5 and 7%; England average for November 2022 was 9%.

Competent staff

The service made sure staff were mostly competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and mostly had the right skills and knowledge to meet the needs of patients. Whilst there were no paediatric trained nurses in the department, most staff had completed paediatric competencies, paediatric life support training (PILS) and European paediatric advanced life support (EPLS) where required. The managers ensured that there was always a staff member on who had EPLS. All nursing staff had to complete a minimum of PILS training level, however, this could not be completed until they had been in the department for 6 months; 65% of staff had completed paediatric training. Staff went to a paediatric ward at Worcestershire Royal Hospital for a day to become comfortable with paediatric observations; 68% of staff had completed this day placement.

Managers gave all new staff a full 4 weeks induction tailored to their role before they started work. This was comprehensive and ensured staff had specific training relative to the department prior to starting. For example, they had paediatric training, sepsis training and blood transfusion training. New starters were supported by professional development nurses (PDN's) and had an inhouse preceptorship programme for 12 months. They supported the learning and development needs of the staff. They ensured that training was completed and booked, and new starters were given extra support if needed.

Managers supported staff to develop through yearly, constructive appraisals of their work. In November 2022, 80% of staff in the service at Alexandra Hospital had received an appraisal. The trust target was 90%. The manager told us that they had a few new starters in the department and several staff on long term sick and maternity leave which was the reason for the low figure. The PDN showed us that all appraisals were booked to be completed on time where possible.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. All staff had competency booklets to complete. They used the Royal College of Nursing competency booklets for emergency nursing. All band 5 staff completed level 1 booklets and band 6 and above completed level 2 booklets. These were very comprehensive and covered all aspects of nursing within the department.

The emergency nurse practitioners had a virtual training session led by a consultant every fortnight. They covered a range of issues for example, limb examination, eyes and head injuries.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff told us that the managers were very proactive at putting staff on courses to develop their skills. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. For example, triage nurses had to have been within the department for 18 months and complete triage training prior to working within the triage setting.

Managers identified poor staff performance promptly and supported staff to improve. We saw meeting minutes from the band 7 meeting where staff performance was discussed, and actions made for improving performance.

The managers wanted to keep their staff and grow them within the department and offered the opportunities to do so. The service had developed 2 rotation programmes; one for band 6 nurses and one for band 7 nurses. The band 6 rotation programme was a 6-month training programme to be a nurse in charge. We spoke to a nurse who was on the rotation who found it a great opportunity and had been well supported in the role. The band 7 rotation was 4 months long and helped the nurses gain insight into the band 7 role.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The service worked well with the patient flow team and bed management team. Bed occupancy at the hospital was high. The patient flow coordinator worked with wards to identify beds from Monday to Sunday. The hospital held bed meetings 3 times a day which reviewed number of patients, performance against the 4-hour target, staffing and bed availability. This resulted in plans for individual patients. We saw that overnight there was a backlog of patients and this was cleared quickly in the morning once ambulatory care ward was opened at 7am. For example, we came in at 7am to see there was an 8 hour wait to see a doctor and by 10am, this had decreased to a 1.5 hour wait.

The service had improved its arrangements for transferring ambulance patients in which allowed ambulances to be freed up more quickly. The Rapid Assessment and Treatment (RAT) area provided swift treatment and triage. There was often a queue of ambulances awaiting the RAT assessment. The hospital had a Global Risk Assessment Tool (GRAT) nurse who worked with the ambulance teams to review the patients and ensure they were safe on the ambulances. We observed a handover between the ambulance team and the GRAT nurse. It was efficient and effective.

There was a Hospital Ambulance Liaison Office (HALO) who worked 10am to 6pm, 7 days a week. They liaised with staff on site and within the ambulance control room to help prioritise patients. We spoke to a HALO who said that they felt they worked well with the hospital team and there was good communication with all staff.

All 44 staff we spoke to said that the department staff all worked together. We were told that doctors, nurses, porters, cleaners, healthcare assistants and any other support staff all had good communication, a good rapport and worked well together. We were told that mostly, the speciality doctors reviewed the patients promptly. However, we were told that it can be difficult getting a surgical review depending on the time as they can be in theatre or clinics. This caused delays within the department.

Staff worked well with primary care to stream relevant patients. This was leading to improved response times for patients with minor injuries.

Urgent and emergency services

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, 7 days a week.

Pharmacy would only dispense drugs on an inpatient drug chart and was open 8.30am to 6pm most days apart from Sunday when they were open a short time.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The service used notice boards around the waiting room and department to promote messages about, for example, healthy living and obesity.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a mental health liaison team who advised on mental health issues. They were on site from 8am to 10pm and off site overnight. The staff reported that they were very supportive. They also would see children aged 16-18 years old who had been seen by a clinician. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The department were in the process of introducing pathways for frequent attenders to prevent crisis and admissions.

In November 2022, 72% of nursing staff had completed their training on the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw that all staff who were outstanding had booked onto it. We were told that there was a limit on the training and there was an issue with the software and it freezing; this meant that staff were struggling to complete it. This had been raised with management.

There was a mental health assessment room at the end of the department. This had no ligature points, but it did have 5 chairs that could be moved or thrown. This was raised at the time of inspection.

Urgent and emergency services

There was a pathway to follow for paediatric patients who presented in the department with mental health conditions and a child and young person's mental health assessment matrix which was completed. This enabled staff to ensure that the patient was getting the right level of care required. Between October 2021 and October 2022, there had been 54 referrals to the Children's Acute Mental Health Services.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patients who visited the department were sent a text on their mobile phone following their visit with a survey. The trust's urgent and emergency care Friends and Family Test performance (% recommended) for November 2022 was 88.81%; there was a 21.26% response rate. The trust aimed to have above 20% response rate.

We saw some outstanding examples of care. A healthcare assistant (HCA) was looking after a patient who suffered from dementia and they had brought them to the nurse's desk and were completing word searches with them, playing music and reading books together. We were told that the patient had previously been distressed and the HCA had taken the patient for a walk outside and this had calmed them down.

Patient dignity was not always fully respected. This was not facilitated by the layout of the department and the lack of available beds. Patients were regularly being cared for in the corridors for long periods of time. We were told that if a patient needed a scan or examination whilst in the corridor, they would be swapped with a patient temporarily within a cubicle to ensure patients dignity. However, we saw a patient being examined in the corridor when staff would have preferred to allocate them to a cubicle, but there were none available. All patients who were cared for in the corridor were given a letter to explain the reasons for this; all patients we spoke to were understanding of the situation.

We observed children being treated in an understanding, kind and sensitive manner. For example, an 8 year old was nervous following a blood sample being taken and a healthcare assistant took them outside to look at an unoccupied ambulance; they were really grateful and happy afterwards.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity where possible. We saw the staff interact kindly with patients throughout the department including whilst they were being cared for in the corridor. Staff told us they mostly put patients with dementia or patients who were at risk of falls in the corridor so that they could be easily seen from the nurse's station. Patients were also remaining in the fit to sit area overnight. This area had 4 reclining chairs within a small cubicle area; this lacked privacy for patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The department had a flow coordinator who assisted with the social needs of the patients and tried to speed up their discharges where possible. We saw the flow coordinator chasing up a home visit to assess a package of care; this freed up the nursing team to care for the patients.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff always made sure patients and those close to them understood their care and treatment. The urgent and emergency care survey 2020 report showed that the trust scored better than other trusts for being listened to; the patients felt the health professional listened to what they had to say. Patients we spoke to generally felt listened to by the team. We saw that a patient who had been in the corridor for a while developed a migraine, the staff recognised this and moved the patient to a quieter area with dim lights as soon as they were able.

However, staff did not always inform patients about their care in a timely way. We spoke to 15 patients in the emergency department and waiting room. Within the waiting room, 5 of the 6 patients we spoke to told us that they were not informed about a plan of care or waiting times. Most patients who were admitted to the department were aware of their plan of care. We observed doctors informing patients of their plan of care on 3 different occasions.

We observed staff calling an elderly patient's relative to update them on their plan of care and then handing the phone to the patients so that they could also speak to them.

Staff talked to patients in a way they could understand, using communication aids where necessary. There were interpreting services available when required.

Where necessary staff supported patients to make informed or advanced decisions about their care. We observed staff explaining to patients, carers and relatives the choices they had, and they were given time to think and reflect. When we spoke to them, they were aware of the decisions available to them.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service was not planned to provide care in a way that met the needs of local people and the communities served. It was starting to work with others in the wider system and local organisations to plan care.

Managers had not planned and organised services to meet the needs of the local population. Services had evolved, patient numbers had increased, and the service did not meet demand. Patients were waiting for long periods of time to be seen in the department and to be moved out of the department into a hospital ward. Leaders analysed capacity and demand daily. However, despite the increased capacity, all patients we saw were safe and well cared for.

Not all emergency department (ED) facilities and premises were appropriate for the service being delivered. There were not enough beds in majors which meant that patients were cared for in the corridors on trolleys. Patients spent long periods of times in recliner chairs and on trolleys. Staff did move patients onto beds if they were in the department for an increased amount of time.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. There was a mental health liaison team who were on site from 8am to 10pm and off site overnight. Staff told us they were helpful and prompt with their attendance. However, facilities for mental health patients were not secure. There was a dedicated mental health room, but the furniture was not secured and could be thrown around.

The service had a paediatric waiting room, but it had no toys or activities and limited resources available for children. We were told it was very hot and rarely used. We saw children waiting in the main waiting room. In majors, there were 3 minimally decorated cubicles for children; these were mostly used for adult patients.

The patients waiting area was small for the number of patients attending. There was a screen which showed wait times, but it was broken at the time of our inspection. Patients told us that they could hear other patients' private information when they registered with the receptionist.

The service had a GP on site from 12pm to 10pm daily. This meant that they could see patients who presented with minor conditions; this reduced the impact on the ED.

The senior leadership team met on a monthly basis and discussed the pathways within the department and made improvements where required. For example, in November 2022, they noted that patients who presented with straightforward Urology issues at Worcestershire Royal Hospital (WRH) were often transferred to the Alexandra Hospital ED when only complex urology cases should be sent over. An action was highlighted to ensure this pathway was followed but informing the leaders at WRH and also the ambulance teams.

Urgent and emergency services

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. We saw a one to one care episode where a healthcare assistant was looking after a patient living with dementia. They were drawing, completing word searches and reading books together. There was a dementia champion who had sourced items to enhance the stay in ED for dementia patients. They were supported by the dementia team. The service had fiddlers, dolls, memory boxes, books, word searches; these were so patients living with dementia could occupy their hands. They had 'This is me' documents which helped to personalise care for patients living with dementia. The dementia champion had brought in some perfumes for the patients as they said that at times, patients had mentioned that they would like to 'smell nice'. The catering department provided dementia food packs which were more nutritious than the food provided normally within the department and included fruit.

Dementia training was provided by the trust within the mandatory training; 94.12% of staff had completed this and 97.53% had completed frailty training.

There was a limited frailty service. There was no frailty team. For patients who needed further support following discharge from the department, there were 2 pathways. These pathways involved reablement with packages of care at home and therapy or a community hospital referral if they were not safe for discharge home. The patient flow coordinator chased these and ensured care was in place where needed. 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 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.

Some areas of the ED provided mixed sex accommodation overnight such as the fit to sit area. This was permitted and within national guidance on mixed sex rules in emergency care, but it was difficult for staff to always respect the individual personal, cultural, social and religious needs of each patient cared for in these areas.

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.

There were some pictorial guides so that people with hearing, learning or speaking difficulties which could help communicate basic needs, such as for pain relief or the toilet.

Staff understood and applied the policy on meeting the care needs of patients with a disability or sensory loss. They escalated to matron and offered one to one care.

Urgent and emergency services

Access and flow

People could access the service when they needed it and received the right care. However, this was not always promptly as waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Performance for the four-hour target averaged 47.8% over the previous 3 months to our inspection.

Waiting times and treatment times were monitored and compared to national standards. 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. The data was discussed at bed meetings 3 times a day, or more if there was increased operational pressures. 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. There was a capacity management policy which detailed the ED safety matrix. It had levels of escalation based on different domains such as ambulance offload time, resus capacity, time from referral to departure and ED staffing. This data generated an ED escalation level which was either normal, busy, critical or overwhelmed. Data showed that between 10 and 23 November 2022, the department was either critical or overwhelmed. 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 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. Patients on the ambulances were considered as patients of the hospital and decisions about their clinical priority was made by a specially trained Global Risk Assessment Triage (GRAT) nurse. They worked alongside the Hospital Ambulance Liaison Officer (HALO) to ensure that the ambulance patients were safely admitted and triaged in line with their clinical priority.

On arrival to the department on 22 November 2022, there were 56 patients within the department, the longest wait was a patient who was waiting for a trauma and orthopaedic bed, and they had been waiting for 24 hours and 28 minutes. The data showed that waits above 20 hours were happening daily. At 8am, there was an 8 hour wait to see a clinician and 6 patients waiting in ambulances with an approximately 4 hours ambulance offload wait. However, by 11am, the waiting time to see a clinician had reduced to 1.5 hours. This was reduced as the ambulatory care unit opened at 7am and was able to accept patients and a medical consultant reviewed the medical patients and sent 5 of them home. This meant that the capacity increased within the department, ambulance offloads were completed, and patients were able to move through the department. This was in line with the urgent care strategy 2019 which had highlighted the need for alternative flows through the department to improve the crowding in ED such as using the ambulatory care unit.

Other areas within the trust had started to board patients. This meant that patients were moved from ED to the wards before a bed was available and a patient who was close to discharge was moved into a corridor or appropriate space. The Alexandra Hospital was unable to do boarding due to the estate. There was no room for extra patients within the ward areas.

The inability to review and admit patients in a timely way increased overcrowding and reduced flow in the department. The Department of Health and Social Care standard for EDs is that 95% of patients should be admitted, transferred or

discharged within four hours of arrival in the ED. This is known as the Emergency Access Standard (EAS). The England average EAS from 7 August to 27 November 2022 was 69.9%. For the same time period, the EAS was 47.8%. During our inspection, on 22 November 2022 the EAS was 46.9% and on 23 November 2022 it was 48%. From 7 August to 27 November 2022 the trust failed to achieve an EAS greater than 63% on any day.

Ambulances taking over 60 minutes to handover patients was significantly higher than the England average. Between 7 August and 27 November 2022 on average, 21.5% of ambulances took over 60 minutes to handover; the England average for the same time period was 12.1%. Within the same time period, ambulance handovers taking between 30 and 60 minutes was the same as the England average at 15%. All patients who were unable to be offloaded by the ambulances were seen by the GRAT nurse. They continued to review the patient every 30 minutes or if ambulance staff escalated the patient. If the patient deteriorated, they would make room for the patient within the department.

The trust had an escalation management plan which was under review. This detailed plans for escalating bed pressures within the department. It also had a protocol for diverting ambulances between sites to ease the pressure.

Patients often did not receive treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than 1 hour. Between 7 August and 27 November 2022, 32.7% of patients were seen within 60 minutes; however, this was higher than the England average for the same timeframe which was 24.3%.

The number of patients waiting longer than 12 hours to admit has been steadily increasing since October 2022. Data provided by the trust showed that between September and November 2022, there were between 32 and 37 patients a month who waited over 12 hours from the decision to admit to be admitted to a ward. In November 2022, the average time in the department was 289 minutes and 622 patients waited over 4 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. Throughout most of our inspection, there were more than 10 patients in ED waiting for a bed in the trust. ED doctors were frustrated by a lack of progress in addressing the trust flow issues and poor hospital flow was identified as having a major impact on the care of their patients.

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. Delays were seen particularly for surgical patients requiring surgical and trauma and orthopaedic reviews. On average, between 14 and 27 November 2022, patients waited 118 minutes for surgical review and 113 minutes for a trauma and orthopaedic review. Most patients within this time period were referred to the medicine team and they waited an average of 76 minutes for a review. Intensive care and paediatric teams saw 100% of the patients referred within 30 minutes.

Managers and staff started planning each patient's discharge as early as possible. There was a patient flow coordinator within the department who organised and chased patients discharges. They worked alongside the physiotherapist and occupational health therapists to ensure a safe discharge for patients who needed further support either at home or with their mobility.

Urgent and emergency services

In November 2022, 5.6% of patients left the department before being seen for treatment. This was higher than the England average which was 3% for the same time period. Nearly 7% of patients who attended the ED in November 2022 reattended within seven days; data was similar for May to October 2022. This was lower than England average which was 9% for November 2022.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There was a patient flow coordinator who assisted with complex discharges and social care needs. Staff supported patients when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. All patients were sent a text message to their mobile phone once they were discharged to ask for feedback on the department.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Complaints were used as an opportunity for learning. Senior nurses told us that lack of communication about the patient plan and waiting time were frequent complaints. As a result, the service had installed a television monitor in the waiting area to display waiting times; it was unfortunately broken at the time of inspection. Local leaders made sure that nurses knew what the plan was for a patient and handovers ensured that the right information was communicated to ensure continuity of care.

The governance team produced a monthly assurance report. This detailed the complaints received and looked at themes found. Complaints were reviewed at governance meetings. During October 2022 there were 4 formal complaints and 3 Patient Advice and Liaison Services complaints. The formal complaints were all responded to within 25 days. Managers told us that they phoned patients to try and resolve the complaint. The service also received 2 compliments for the service in October 2022.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw in the ED weekly brief from 7 November 2022, which was sent to all staff, that it highlighted communication as the main complaint theme. Staff told us that patients complained about lack of communication at times. This was due to the increase in footfall of patients and meant that the pressures within the department were higher and there was less time to communicate with all the patients. We spoke to patients within the waiting room and 5 out of 6 of them said that they were not informed about the plan and how long they were likely to be within the department for.

Is the service well-led?

Requires Improvement ↑

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

Urgent and emergency services

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 matron, divisional director of nursing, a divisional director of operations, clinical lead, directorate support manager and a clinical director. 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 was an emergency care consultant who was responsible for clinical care in the department, and who worked alongside the matron to provide local leadership direct to the emergency department (ED) team. The divisional director of nursing attended the department weekly. The senior leadership team met on a monthly basis to discuss quality in the department. 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. They also did at least 1 night shift a month. 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. They all had respect for each other and their roles and they were proud of their team. 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. They worked hard to ease the pressures of working in such a busy environment.

The nurse in charge of the shift had responsibility for overseeing the smooth running of the whole department, including monitoring waiting times and moving staff around the department to cope with demand and capacity. They escalated patient concerns to medical staff or senior managers when and if appropriate. The matron 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 matron worked closely with the matron for the medicine service. They had a good relationship which enabled them to proactively manage the flow through the departments together. The matron also completed on calls for the whole hospital which meant that they had an overall view of the flow within the hospital.

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 worked well together and spoke highly of each other's abilities and support.

Staff development was encouraged at all levels and senior staff told us they were proud of the department's ability to 'grow their own' senior staff. Nurses told us they were encouraged to apply for more senior roles within the department. The managers told us that the previous staff survey had said that staff felt undervalued and had no professional development. Therefore, they had recently brought out rotational posts for band 6 and band 7 staff nurses to go into and offered other training support. These short-term rotations enabled staff to gain leadership skills and insight into the nurse in charge role. This enabled staff to develop their clinical and leadership skills in an area where they already had a good working knowledge and the support of good teamworking.

In the staff meeting room within the department, there was a 'hassle board'. This was where staff anonymously put post-it notes on the board with issues that they had and then responses were written. For example, 'bladder scanners always broken and can never find them', the response was '2 new ones have now been ordered'.

Urgent and emergency services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, but it was not fully embedded. Leaders and staff did not fully understand it or know how to apply them and monitor progress.

There was a trust wide plan for improving the flow of the patients through the hospital but it was not working. There was still poor flow through the department which led to long delays for the patients. The trust wide plan included boarding of patients, however, this was not done in Alexandra Hospital due to the estate and lack of space to do so.

The pathways that the hospital used to move patients promptly into the community were not working as there was a lack of community beds. The leaders were working with the Integrated Care Board (ICB) to aid patient flow. The ICB were doing regular reviews in order to facilitate flow within the community.

The trust strategy was 'Putting Patients First'. They used this to develop a 'Clinical Services Strategy to 2025'. The document set out the clear roles for the hospitals including moving all hospital births, inpatient children's services and emergency surgery away from this hospital to the Worcestershire Royal Hospital site; this had been completed. The strategy for urgent and emergency care stated that by the end of 2021, they would have embedded a frailty sensitive approach across the hospital and specialities. This included more generalist medical roles across the local system to support people who were frail and complex. We were told that a frailty pathway was limited. There were no frailty practitioners within the department. They did have access to therapy services but this was limited and often meant patients were admitted under the medical teams. We were told there was little support to keep the patients out of hospital. Within the strategy, by 2025, they wanted to build on their frailty service development and have specialists in frailty management working within ED.

There were elements of the strategy, which was developed in 2019, which had been delivered. We saw that rapid streaming within ED was happening, there was good mental health provisions and there was a good cross-country approach to sustaining 2 emergency departments with collaboration from all of the teams. The leaders in the service were not fully aware of the strategy for the department. They said that more planned surgery would be done at this site and all emergency surgery would be done at Worcestershire Royal Hospital. However, were unable to specifically state what the vision or strategy were for the ED.

The strategy aimed by the end of 2025 to have a more digitally-enabled 'virtual' care delivery across the services to give more options to assess urgent care.

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.

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 worked well together.

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. Senior staff worked clinical shifts in the department regularly to cover staff shortages and help teams deal with the workload. There were team meetings and daily huddles where staff could raise issues.

Junior doctors spoke highly of their training experiences in the department and said their consultants were very approachable.

The department was often overwhelmed with patients and there was not always enough staff to carry out all of the required tasks in a timely manner. The managers recognised this and stepped in to help when required.

We saw that staff well-being was at the forefront of the managers minds. There was a well-being champion who was trained to recognise signs of stress and anxiety. They ran drop in sessions for the staff, had created a small well-being team and supported staff with their mental health. They had access to a clinical psychologist if required. Staff told us that they were very supportive and really listened to them. The well-being champion had also introduced 'start well to end well'. It was an initiative to start and end the shift together. All staff finish shift with a debrief and leave the department together. This gave the staff an opportunity to discuss the positives and negatives of their days and support each other.

There were 'happy café' packs which were in the seminar room to help take staff's mind off things and relax. They focussed on wellbeing and included colouring sheets, recipes, mindfulness and relaxation tips. They also included information for how staff could get extra support with their mental health if required.

The department had monthly team meetings for band 2's, 5's, 6's and 7's. They were unable to hold a full team meeting for all staff grades due to the nature of the service. These meetings discussed training, morale, incidents, complaints and any other updates. The service also had communications groups led by band 7 staff. Staff were allocated to different teams and had half a day's meeting every 6 months. This involved team building, training updates, information about the department and any complaints or incidents.

There was an excellence box for sharing excellence of staff. We saw over 50 examples displayed where staff had expressed gratitude to other staff members for their assistance or praised how they handled a situation. For example, 'Went above and beyond on their patient care. Patient was extremely thankful. Great wound care' and 'To all reception staff for working together as a team and being strong front of house when times get busy and patients are upset. We could not do without you, thank you'.

Whilst we were on inspection it was 'Healthcare Support Workers Day'. All support staff were invited to attend a small party within the department. They each were given a certificate of appreciation and some gifts. The staff who attended told us that they felt appreciated and everyone was a great team together.

Governance

Leaders mostly 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. However, there was a lack of oversight for some of the issues within the department including lack of paediatric nurses, duplicating of medicine charts and lack of strategy for managing the poor flow.

Systems were in place to assess, monitor and improve the quality of care within the ED. Governance processes were mostly effective to ensure that the service was always safe and performed well. The ED had joint weekly governance

meetings with the Worcestershire Royal Hospital ED senior leadership team. They reviewed performance, incidents, complaints and audits and had common themes across the directorate. We did not see any associated action plans alongside the meeting minutes. They investigated serious incidents which happened in the departments and shared learning. They did not investigate within their own departments which meant it was done objectively and with no level of bias.

We were told that there had been more staff who had joined the governance team and they were very responsive. They produced matron assurance reports for the department which were presented on a monthly basis; these included incident data, risk register, falls data, training and appraisal data and audits scores.

We found that whilst some improvements had been made in relation to concerns raised at our previous inspection not all of these had been fully addressed. For example, there were long waits for ambulance handovers, patients were not always assessed in a timely manner and patients did not always get a medical and speciality review promptly. However, we saw that the trust had put systems in place to make improvements in these areas and ensure that the patients in the department were safe. There was a Global Risk Assessment Tool nurse who was responsible for the patients on the ambulances and triaged them to ensure they were safe. There was a Rapid Assessment Triage area which enabled rapid assessment, including blood tests and scans, and the movement through the department. There was a 'fit to sit' area where patients who were well enough could sit and have treatment or tests. There were 5 corridor beds with a dedicated corridor nurse which increased the capacity within the department.

Regular audits were completed to assess and monitor the quality of care. However, we did not always see that there was an action plan with the audit. The trust provided audit data following the inspection, but action plans were not provided therefore it was unclear if the audits were used to initiate improvements within the department.

There were no paediatric trained nurses within the department; 9% of their attendance, on average, were children. The department had paediatric competencies that staff were working towards and trained staff in paediatric life support and completed emergency scenarios. However, this was not on the risk register and the department did not have signage to highlight that it was not a paediatric ED. We were not assured that the managers deemed this to be a risk within the department.

There was a lack of strategy for managing the poor flow within the department. The managers actively discussed the poor flow daily and moved patients through the department when possible. However, patients were consistently not receiving treatment within agreed timeframes and national targets and staying in the department for long periods of time. There was no clear strategy for improving the flow for the patients and sustaining the improved flow.

There was a lack of oversight regarding medicines management within the department. We found duplicated medication charts and omissions of medications in several medication charts. Managers had not picked up that this was an issue and could have caused harm to patients through overdose or delay to treatment. We raised this with the managers at the time.

There had been a new hourly checklist that had been recently implemented in the department. Staff were not completing this on a regular basis. Senior leaders were aware that completion was an issue, but improvements had still not been made. They found it hard to get staff to engage in the process. The poor completion was discussed in the handover and staff were asked to complete it. However, later that day we saw that these staff had still not completed these documents. Managers showed us an updated version of the chart that was due to be released which had improvements and made it easier for staff to complete.

Monthly band 7 meetings were held with the matron. We were told that concerns could be raised and following these meetings, the sisters shared updates with the staff through handovers and weekly briefs.

Management of risk, issues and performance

Leaders and teams had not used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had some plans to cope with unexpected events.

There was a track record of ineffective performance management. Performance in the ED had been below average for a long time without resolution. At service level, performance monitoring was not always used effectively. There was real time oversight of breaches through their electronic system and a safety huddle occurred 3 times a day, which was attended by the ED clinical team. However, there were still long waits within the department and these meetings did not always lead to action to solve these problems.

The department risk register listed 3 extreme-level risks, and 5 high-level risks, most of which were lowered to some degree by mitigating actions. The 3 highest risks were:

ED crowding and exit block

Ambulance off-loads

ED waiting room is unsafe.

For example, ED crowding and exit block had a risk score of 25 (extreme). They had a target rating of 9 (high). This was due for review 31/12/2022. This risk remained high due to the poor flow within the hospital and increase in patients. The control measures in place was a rapid assessment for all patients who were brought in by ambulance and corridor care to increase the bed capacity. The patients were being cared for safely within this extreme environment.

The service recorded data on speciality response times. Delays were seen particularly for surgical patients requiring surgical and trauma and orthopaedic reviews. On average, between 14 and 27 November 2022, patients waited 118 minutes for surgical review and 113 minutes for a trauma and orthopaedic review. The majority of patients within this time period were referred to the medicine team and they waited on average 76 minutes for a review.

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 2022.

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 more than an hour before a set of observations were recorded.

ED mortality and morbidity meetings took place to discuss any deaths which had occurred unexpectedly in the ED and were used to identify learning and reduce risks to patients. The reports from May to June 2022 showed 4 cases had been discussed and reviews completed. There were no identified themes or learning points and not all aspects of the

structured judgement review were completed. One article was added to the learning log for further reading. These were discussed and presented on the ED board rounds. They were also discussed at the Serious incident Review and Learning Group. This was a multidisciplinary and cross-divisional governance meeting. If a concern was found, a comprehensive investigation was completed.

Information Management

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

Arrangements to ensure data quality was consistent were not yet in place. Data collection in the ED was not always reliable. They used both computer and paper based systems; this made it difficult to effectively audit patients data. Patient observations were initially recorded on the computer at point of triage and subsequently these were recorded on paper. There was a chance that the change to paper would mean that the staff would not see a patient's condition deteriorate through increasing NEWS2.

There were effective arrangements to ensure that externally required data and notifications were reliable and submitted in a timely way.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff had been asked to complete a survey on an annual basis. We saw that the managers acted upon the results and made changes within the department. For example, staff wanted further professional development and the managers created rotational programmes and training days. However, when we asked, staff could not think of an improvement which would make a difference to patients which had happened because of a staff suggestion. Staff had not been consulted about strategic plans.

The department gathered patient views and reviewed these on a monthly basis. All patients who were discharged from the department received a text message, where possible, to ask their view on the service. The majority of the feedback from patients was that the waiting times were too long. The service had provided a screen in the waiting area which gave patients the length of wait time. During our inspection, we found that it was not working.

The service was working with commissioners to improve access to emergency care. The ICB were completing regular reviews on the service to help facilitate the flow into the community.

Learning, continuous improvement and innovation

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

The service had not systematically benchmarked its processes with the best performing urgent care services.

The service had a wellbeing champion and 2 advocates within the department who supported staff and recognised the signs of staff burn out. They met with staff who were off sick with stress or anxiety. They planned wellbeing days for staff,

drop in sessions and tried to bring staff together as a team to ensure good support. A staff member told us that the wellbeing champion had recognised that they were feeling anxious following an incident and sat and listened to them debrief about it. The staff member reported that they felt very supported and much better following the support from the wellbeing lead. They had brought in 'start well to end well'; this was an initiative to start the shift and end the shift all together with a brief and debrief. All staff we spoke to felt very supported and felt that the managers really thought about their mental wellbeing.

The dementia care in the department was very good. There was a dementia champion who was dedicated and passionate about dementia care. They had created activities and resources to ensure that patients who were living with dementia were supported in the department. We saw one to one care which was personalised and very caring.

The service had going home food packs. These were given to patients who were discharged and lived alone. They contained bread, milk, butter and soup.

Worcestershire Royal Hospital

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www.worcsacute.nhs.uk

Description of this hospital

Medical care (including older people's care)

Our rating of this location stayed the same. We rated it as requires improvement because:

- Although the service generally had enough staff to care for patients and keep them safe, the vacancy rate for medical staff was high. The service had high rates of bank and agency staff. Medical staff did not always keep up to date with training in key skills, including safeguarding training. 'Pods' on Laurel 2 ward were not well maintained and posed an infection control risk. Staff did not always have all the equipment they needed to care for patients. Patients were regularly admitted onto discharge units against standard operating procedure criteria, and we could not be assured that risks were fully assessed and mitigated. Staff did not always manage medicines well. Though the service generally investigated safety incidents well and learned lessons from them, this was not the case on all units.
- Outcomes for patients were mixed. People could not always access parts of the service when they needed it, particularly stroke services. Outliers in national audits were not always addressed. Medical staff did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff did not always feel respected, supported and valued. Morale was low amongst some staff, who felt that their concerns were not always listened to by leaders.

However:

- The service generally controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service through comprehensive repeat audits, and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- 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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

We inspected this service on the evening of 21 November, and 22 and 23 November 2022. This was an unannounced full core service inspection looking at medical care. We visited the following medical wards and speciality services:

- Acute Stroke Unit
- Acute Respiratory Unit
- Medical Assessment Unit
- Avon 2 ward
- Avon 3 ward
- Avon 4 ward
- Endoscopy
- Laurel 2 (oncology) ward
- Laurel 3 (haematology) ward
- Pathway Discharge Unit
- Evergreen Discharge Lounge

The team that inspected the service comprised of 1 CQC inspector, 2 CQC inspection managers, a specialist advisor with expertise in medical care for 2 days, and another specialist advisor with expertise in medical care for 1 day.

During our inspection we spoke with approximately 30 staff members. This consisted of nursing staff, including ward managers and healthcare assistants, medical staff, students and a pharmacist. We spoke to 11 patients and we reviewed 10 patient records.

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

Urgent and Emergency Care

Our rating of this location improved. We rated it as requires improvement because:

- Staff did not always have training in key skills. Mandatory training levels for medical staff did not meet the trust target of 90%. Staff did not always store medicines safely.
- Staff provided good care and treatment, gave patients enough to eat and drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.

Our findings

- Staff treated patients with compassion and kindness and as individuals. They took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.
- While people could access the service when they needed it, they had to wait far too long for assessment and treatment. There were delays in moving patients off ambulances into the department. This resulted in delays in assessment and treatment for some patients.
- Systems to manage risk, issues and performance were not effective due to capacity and flow issues.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Pain relief was not always given to some patients when they needed it.
- Although staff respected patient's privacy and dignity, corridor care meant they could not provide private and dignified care to all patients.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- 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. The service engaged well with patients and the community to plan and manage services.

How we carried out the inspection

We carried out an unannounced inspection of the urgent and emergency care services over 3 days. We went to the unit on the late evening of the first day and then spent 2 further days on site.

The team comprised a CQC lead inspector, a CQC team inspector, a CQC inspection manager and a CQC medicines inspector. We were accompanied by 2 specialist advisors who were a senior emergency department nurse and a consultant in emergency care.

During our inspection we spoke to 10 patients and 4 relatives and looked at 8 sets of patient records.

We interviewed 28 members of staff including nurses, doctors, healthcare assistants, senior managers, staff from the professions allied to medicine and ancillary workers.

The inspection team was overseen by Charlotte Rudge, Interim Deputy Director for Operations.

Medical care (including older people's care)

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. Data we received after the inspection showed that 89.94% of nursing staff in specialty medicine across the Worcestershire Royal and Alexandra Hospital sites were up-to-date with their mandatory training, just below the trust target of 90%. In oncology, haematology and palliative care this figure was 92.61%, and in endoscopy 98.7% of nursing staff were up-to-date.

Medical staff received but did not always keep up-to-date with their mandatory training. Data we received after the inspection showed that 67.31% of medical staff in specialty medicine across the Worcestershire Royal and Alexandra Hospital sites were up-to-date with their mandatory training, significantly below the trust target of 90%. In oncology, haematology and palliative care , this figure was 82.39%, and in endoscopy 90.91% of medical staff were up-to-date. Several of the doctors we spoke to said that they rarely had time to complete training during working hours and had to do this in their own time.

The mandatory training was comprehensive and met the needs of patients and staff. The trust provided a package of mandatory training which included basic life support, safeguarding, moving and handling, fire safety, infection prevention and control, health, safety and welfare, information governance and data security, conflict resolution, equality, diversity and human rights and preventing radicalisation.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Clinical staff received Mental Capacity Act and Deprivation of Liberty Safeguarding training.

Managers monitored mandatory training for nursing staff and alerted them when they needed to update their training. Ward managers told us that divisional directors emailed the ward to alert managers as to which training was outstanding for their staff. Managers then cascaded this to staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were not always up to date with training on how to recognise and report abuse, although staff knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff received safeguarding adults training and safeguarding children training to a minimum of level 2, depending on their role. Data

requested after the inspection showed that as of 31 October 2022, 87.72% of nursing staff in specialty medicine at Worcestershire Royal had completed the required training within the last 3 years, slightly below the target completion rate of 90%. In endoscopy, 93.33% of nursing staff had completed the required safeguarding training, and in oncology, haematology and palliative care, 89.58% of nursing staff were compliant.

Medical staff received training specific for their role on how to recognise and report abuse, but this was not always up to date. Medical staff received safeguarding adults training and safeguarding children training to a minimum of level 2. Data requested after the inspection showed that as of 31 October 2022, 53.7% of medical staff in speciality medicine had completed level 2 training within the last 3 years. In oncology, haematology and palliative care, 75% of medical staff had up-to-date safeguarding training. These figures are below the trust target of 90%. Medical staff in endoscopy were compliant with safeguarding training however, with a 100% completion rate.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to could give examples of safeguarding situations they had raised, including a patient whose relative had become abusive towards them, which involved working with the police.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Most of the staff we spoke to knew how to make a safeguarding referral and where they could find information on this. A Healthcare Assistant told us that they would escalate any concerns they had to the nurse in charge. However, not all staff could recall who the safeguarding lead for the service was.

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were clean and generally well-maintained. However, the Acute Stroke Unit (ASU), was somewhat cluttered with equipment such as chairs and hoists lining the corridors, but labels on the equipment showed that it was operational and clean. In the acute oncology bay on Laurel 2 ward, we noted significant wear and tear on the 3 patient isolation 'pods'. The pods, which were installed to provide enhanced prevention of cross infection to the trust's most vulnerable patients for Acute Oncology during the Covid-19 pandemic**,** consisted of hard plastic sides with a soft plastic screen at the front. The soft plastic had torn in places, and staff had temporarily fixed holes with micropore tape. This posed an infection control risk, particularly given that oncology patients are more likely to be immunocompromised than other patient groups. The pods were added to the divisional risk register immediately after our inspection. Since our inspection, the trust have provided regular updates regarding the pods which have now been replaced with more solid structures. The risk was closed on the risk register.

In the latest Patient-Led Assessment of the Care Environment (PLACE) report data available from 2019, the trust scored 96.63% for condition, maintenance and appearance.

The service generally performed well for cleanliness. The trust monitoring team carried out cleanliness audits in line with the National Standards of Healthcare Cleanliness. They displayed star ratings in patient areas, ranging from 1 to 5,

derived from the overall audit score. We received scores for 8 specialty medicine wards at Worcestershire Royal from the November 2022 audit. Five wards scored the top 5 star rating, meaning that they had met or exceeded audit targets. Two scored 4 stars, meaning that they scored 1 to 3% below audit targets, and 1 scored 3 stars, meaning that they scored 4 to 6% below audit targets. The trust told us that any area with a 3 star rating or below was subject to an improvement plan.

The trust scored highly for cleanliness in the latest PLACE report data available from 2019, with a score of 98.51%. This was roughly in line with the national average of 98.6%.

Cleaning records were generally up-to-date and demonstrated that all areas were cleaned regularly. Daily cleaning records were largely in the form of laminated tick sheets which were placed on ward bay doors. The records had generally been filled and signed on the day of inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE).

All staff were bare below the elbow and wore surgical masks in clinical areas as per trust policy. All patients we spoke to said that staff always washed their hands or used alcohol gel before treating them. Audit data from the 3 months before the inspection showed that all speciality medicine wards were over 99.5% compliant in hand hygiene practice. Instructive handwashing posters were seen above sink areas, and there were also posters on the walls which encouraged visitors to clean their hands.

Disposable gloves and aprons were widely available in clinical areas. However, we saw a staff member go in and out of a side room with an infectious patient in without gloves or an apron on Discharge Lounge. After the inspection, managers ensured that PPE was available directly outside side rooms. Spill kits were available and accessible to staff to manage blood and other bodily fluid spills.

We reviewed results of the High Impact Intervention Audit for ASU, Acute Respiratory Unit and Avon 3 and 4 wards. The audit intended to prevent infections in chronic wounds, as well as infections associated with urinary catheters, peripheral vascular access devices, such as cannulas, and central venous access devices like ports. Audit data from the 3 months before the inspection showed results between 86.4% and 100% in all areas for all wards.

Staff carried out infection risk assessments for new admissions including screening for COVID-19, MRSA, and where risk criteria are met, Carbapenemase-Producing Enterobacterales (CPE). There have been outbreaks of CPE across Laurel 1, 2 and 3 wards since June 2021. At the time of inspection, the shared kitchen between Laurel 1 and 2 wards was out of use as a result of a new outbreak affecting 3 patients. We were assured that the risk was being managed. There was a clear action plan in place, with input from internal teams, such as microbiology and estates as well as external stakeholders, such as NHS England. There were fortnightly outbreak control meetings ongoing, and CPE was on the risk register.

Data requested after the inspection showed that between November 2021 and October 2022, there had been 34 *Clostridium difficile* (C.diff) infections associated with medical wards, with onset either in hospital or in the community. There were no MRSA infections.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment and used green ‘I am clean’ labels to show it was clean. Labels seen all had that day’s date on.

There was evidence of good decontamination processes in endoscopy, in compliance with the Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. There were separate 'clean' and 'dirty' rooms, and a good flow of clean and dirty scopes. Staff had specific training on cleaning the equipment.

Environment and equipment

The design and maintenance of facilities, premises and equipment generally kept people safe. Staff were trained to use them. The use of facilities did not always keep people safe. Staff mostly managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Most patients said that staff answered call bells quickly, although staff can be very busy at times. A patient on Acute Stroke Ward did not have a working call bell, but this had already been reported to estates.

The design of the environment followed national guidance but staff did not always use it correctly. All wards visited had swipe access and/or intercoms for security. However, on the evening of 20 November 2022, the main door to the Cardiac Catheterisation Unit was propped open with a tea towel. Fire doors were clearly labelled. However, the fire door in the entrance corridor to the Pathway Decisions Unit (PDU) was open, despite signs on the door informing staff to keep it shut.

Staff carried out daily safety checks of specialist equipment. Staff carried out and documented daily checks on defibrillators. They also checked and signed to say that security tags were intact on the rest of the emergency trolley. After use of the emergency trolley, re-stocked items were documented and signed for. Staff undertook full stock checks of emergency trolleys once a month. 2 staff members signed off this check. Samples of consumable items and intravenous fluids checked on emergency trolleys were all within their expiry dates.

The service had suitable facilities to meet the needs of patients' families. Staff told us about the recently introduced Peony Room, a relatives' room where families of patients who are nearing the end of their lives can take a break from the ward environment and have refreshments. The idea of the room came from feedback from bereavement surveys which highlighted that there was a lack of space for relatives to go to have some time for themselves.

We spoke to relatives of a patient on Medical Assessment Unit (MAU) who were complimentary about the service and facilities offered to them when the patient was very unwell, saying that they could visit at any time, and were offered refreshments after travelling in.

The service generally had enough suitable equipment to help them to safely care for patients. Staff told us that they generally had the equipment they required. Most patients we spoke to said that they felt that the equipment on the wards was suitable for their needs. A patient told us they had been given a raised toilet seat to assist them in the bathroom. Another patient spoke about being given a recliner chair to help with their dizziness. Staff told us that specialist bariatric equipment could be ordered in from an external company when required. However, there was no hoist on Discharge Lounge despite receiving patients who could not mobilise without one. There was also no macerator available on Discharge Lounge, meaning that used bedpans and bottles were disposed of in clinical waste bins. A staff member on PDU told us that they did not have enough chairs to allow patients to sit out of their beds despite ordering them.

The trust kept a comprehensive log of medical equipment and generally ensured that operational equipment was maintained. Of the 2010 medical devices which were operational, 201 or 10%, were outside of their next scheduled service date at the time of our inspection. We saw evidence of a robust annual electrical safety testing programme carried out by an external company. All fire extinguishers checked were within their service dates.

Staff mostly disposed of clinical waste safely. There was evidence that clinical, offensive and domestic waste were segregated in line with guidance. We checked 5 sharps bins over 3 wards. All 5 bins were properly assembled and clean. Three of the 5 were dated, and 4 of the 5 were temporarily closed. The bin which was not closed was overfilled, as plastic tubing was seen spilling over the top of the bin. This was rectified at the time of inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and generally removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration, however key information was not always shared during handover of patients to the Discharge Lounge.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We reviewed 10 sets of patient notes from 4 different wards/units. Staff recorded National Early Warning Scores (NEWS) in a timely manner in all the notes seen. There was no evidence of a patient having to be escalated due to a deterioration in the notes we reviewed. The trust had a management of the deteriorating patient policy which was comprehensive and in date.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. Staff completed a bundle of risk assessments for each patient upon admission. This included risk assessment for Venous thromboembolism (VTE), falls, manual handling, oral care, nutrition, and bed rail safety. For pressure ulcer risk assessment, Waterlow scores were recorded as well as SSKIN principles including ensuring patients are on a supportive surface, skin inspections, keeping moving, ensuring that if incontinent, patients are clean and dry, and that nutrition is adequate. Risk assessments had been completed and reviewed as necessary in all the records seen.

Staff generally knew about and dealt with any specific risk issues.

Staff completed falls care plans for those assessed as at risk of falls and provided aids accordingly.

Staff carried out intentional care and comfort rounds every 2 to 4 hours. Patients had appropriate mattresses based on their risk of pressure ulcers and were regularly repositioned which was documented on intentional care and comfort round charts. On Acute Stroke Ward, where patients may be at particular risk of pressure ulcers due to a loss of mobility, the Tissue Viability Team had installed a tissue viability trolley. This included consumables required for pressure care and a folder containing pressure care ‘top tips’, a photographic guide to ulcer staging, advice on the diabetic foot care pathway and contact details for the Tissue Viability Team.

All patients had a nutritional care plan in place. Where patients were fed by nasogastric tube, the correct prescription and safety checks had been completed.

There was evidence of sepsis screening in records reviewed. In 4 of the 5 cases where this was required, the patient was seen by a doctor and started on antibiotics within 1 hour. We saw dedicated sepsis trolleys on several wards.

Staff on Discharge Lounge and PDU told us that patients were frequently admitted in times of pressure by senior managers against the exclusion criteria set out in the standard operating procedures (SOPs) for these units. Exclusion criteria for Discharge Lounge included patients who needed regular controlled drugs, patients with infections who needed barrier nursing, and patients with complex mental health needs. Exclusion criteria for PDU included patients who required therapy input, patients on stroke pathway and patients on a neck of femur fracture pathway. During our inspection, a patient on Discharge Lounge was being nursed in a side room due to infection, and another was prescribed morphine. Staff on PDU told us that a patient had been admitted the previous day with incomplete therapies. Staff told

us that they felt these admissions increased risk on the units, and we saw that several incident reports had been logged by staff regarding the admissions. As the units were intended for medically fit for discharge patients, they did not have dedicated medical staffing. Staff could bleep a medical outlier doctor for medical support, but they told us that they could take a long time to arrive as they were very busy. Discharge Lounge was also in a remote location on the hospital site. PDU had no pharmacy cover and there was no regular funded input for therapies in place on either unit, although a senior manager told us that they managed risk when a patient was transferred with incomplete therapies by logging an incident and escalating via the divisional management team for therapy input. They also told us that each morning, any patients admitted to the Discharge Lounge and PDU against their SOP criteria were repatriated to base wards. However, we could not be assured that any other risk assessments or mitigations were in place for the duration that patients were on the units. Although a handover sheet was completed by staff on base wards, staff on Discharge Lounge particularly told us that information was not always accurate. After the inspection, managers produced an action plan which included adding patients admitted outside of SOP criteria to the risk register, and the introduction of a governance dashboard including both units to allow easier visualisation of the risk register and open incidents and complaints.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff told us that they had access to a dedicated mental health team to provide mental health support.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff on Discharge Lounge told us that they did not always receive a full handover from base wards when patients were transferred to their care. For example, they had received a patient with dementia who they were told had no specific risk factors on the internal handover transfer sheet. However, staff found on arrival that the patient was very agitated and somewhat aggressive, needed close monitoring from staff.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a shift handover between nursing staff on MAU. The nurse in charge did not start the handover until all nursing staff were present, and gave all staff coming onto duty a handover sheet which listed each patient on the ward and a brief history and treatment plan in an SBAR (situation, background, assessment and recommendation) format. Information such as diabetic status was highlighted, as well as which patients needed 1-to-1 support from a staff member. The handover also stated whether a DNACPR, a decision not to undertaken cardiopulmonary resuscitation in the event of a cardiac arrest, was in place. Patients who were ready for discharge were highlighted. The nurse in charge also reminded staff of the 'Topic of the Week', which was learning around mouth care.

Medical staff had a 'huddle' which took place at 9am on MAU. Junior medics shared a list of patients who had been clerked by a junior medic overnight, and now needed a consultant review in the 'huddle'. The nurse in charge told us that after the 'huddle', medical staff would report to the nursing station where nursing staff would highlight patients on the ward who needed a medical review as a matter of priority.

Staffing

The service generally had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the use of bank and agency nurses was generally high, and some speciality nursing shifts were not always covered. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

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

Medical care (including older people's care)

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. Managers monitored staffing levels twice daily via a safe staffing app, and adjusted staffing levels according to any shortfalls. Staff on Laurel 2 ward told us that Laurel 2 and 3 wards supported each other with staffing where required.

The ward manager could adjust staffing levels daily according to the needs of patients. A ward manager we spoke to said that if a patient required 1-to-1 care from a healthcare assistant (HCA), the staff member would be taken out of the circulating staff count for the day.

The number of nurses and healthcare assistants generally matched the planned numbers. In the 6 months prior to the inspection, the fill rate of day shifts versus planned numbers was an average of 91% for registered nurses on core nursing rosters. On night shifts the fill rate was 96%.

In the same period, the fill rate of day shifts versus planned numbers was 87% for HCAs on core nursing rosters. On night shifts the fill rate was 93%.

However, there were lower fill rates for some specialist non-core nursing shifts. For example, there was an average fill rate of 59% for Acute Respiratory Specialist Nurse shifts, and a 51% fill rate for Acute Stroke Specialist Nurse shifts. In endoscopy, there was a 60% fill rate for registered nurse shifts, though the fill rate for HCAs was 92%.

The service had variable vacancy rates. In the 6 months prior to the inspection, substantive vacancy rates amongst nursing staff ranged from 7.91% to 10.52%. The service told us that they were recruiting internationally for permanent nursing staff, as well as engaging with potential employees at events such as public and university job fayres.

The service had variable turnover rates. In the 6 months prior to the inspection, turnover rates amongst nursing staff ranged from 11.54% to 13.21%.

The service had variable sickness rates. In the 6 months prior to the inspection, rates of sickness absence amongst nursing staff ranged from 3.84% to 5.6%.

The service had generally increasing rates of bank and agency nurses used on the wards. We received data on the use of bank and agency staff on 11 medical wards. In the 6 months prior to the inspection, the rate of bank and agency nursing staff usage on the wards had generally increased. Agency and bank staff accounted for more than 25% of nursing staffing on 7 of the 11 wards.

Managers requested staff familiar with the service. Ward managers told us that they tried to block book agency staff wherever possible to ensure familiarity with the ward.

Managers made sure all bank and agency staff had a full induction. However, not all agency staff fully understood the service. Managers told us that all agency staff receive an induction. However, on the evening of 21 November 2022, 2 agency nurses were staffing the Evergreen Discharge Lounge. The nurses did not have swipe cards to access the wards, computer login details or credentials to use blood glucose monitoring machines. They also did not understand the emergency evacuation procedure for the unit. This was escalated to the senior manager on call. Since the inspection, there must be a substantive nurse on each shift to maintain continuity and safety. The trust has also started actively recruiting for permanent staff for the unit.

Medical care (including older people's care)

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. Substantive vacancies were high however, and bank and locum staff filled shifts. Staff were concerned about the skill mix of medical staff at times.

The service had enough medical staff to keep patients safe.

The medical staff matched the planned number. Although vacancy rates were high for medical staff, few medical shifts remained unfilled by bank or locum staff between May and October 2022.

The service had high vacancy rates for medical staff, but this was generally reducing. In the 6 months prior to the inspection, substantive vacancy rates for medical staff generally reduced. In May 2022 the vacancy rate was 20.7%. In October 2022 the rate was 17.1%.

The service had gradually reducing turnover rates for medical staff. In the 6 months prior to the inspection, turnover rates for medical staff gradually reduced month on month. In May 2022 the turnover rate was 13.32%. In October 2022 the rate was 9.61%.

Sickness rates for medical staff were low and stable. In the 6 months prior to the inspection, rates of sickness absence amongst medical staff were low and generally stable, with rates ranging between 1.24% and 2.66%.

The service could not provide data on rates of bank and locum staff as a proportion of total staffing. However, over 34,500 working hours were filled by bank and locum staff between May and October 2022.

Managers could access locums when they needed additional medical staff.

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

The service did not always have a good skill mix of medical staff on each shift. Some of the medical staff we spoke to said that while skill mix in the day on wards was generally good, they were concerned that there was only 1 medical registrar at night. A doctor told us that although they had been told the trust intended to have another registrar at night by August 2023, the current situation was “unsustainable” given the volume of patients in the service.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, generally stored securely and generally easily available to all staff providing care, however on the Discharge Lounge not all patients notes were available.

Patient notes were comprehensive and all staff could access them easily. Records were paper-based, and staff completed them thoroughly and legibly, signing and dating where required. Records were easy to access on wards.

When patients transferred to a new team, there were sometimes delays in staff accessing their records. Staff on the Discharge Lounge told us that patient records were not always accessible to them when patients were moved onto the unit from base wards. There were no notes available for 6 of the 11 patients on the unit at the time of inspection. Staff

told us that patients could be waiting for several hours in the lounge and although they usually had access to an internal transfer handover sheet, they could not always be sure of what medications patients needed, for example, without access to drug charts in the notes. Since the inspection, staff are required to transfer patient records along with patients on admission to Discharge Lounge.

Records were generally stored securely. Staff kept patient notes in trolleys next to the nurses' station on most of the wards we visited. Although the trolleys were not locked, there was always a staff member at the station during our inspection who had oversight of the notes. On Avon 3 and 4 however, bed end notes were hooked onto ledges in corridors where there was not always staff oversight. On Discharge Lounge, we found loose papers inside a patient's notes including a doctor's 'job list' with patient names on, and a printout of an email about another patient. Discharge Lounge staff submitted an incident report about this when it was brought to their attention.

Medicines

The service did not always use systems and processes to safely prescribe and administer medicines safely. The service recorded and generally stored medicines safely.

Staff did not always follow systems and processes to prescribe and administer medicines safely. Medicines on PDU were reviewed by a pharmacist specialist. We found that medicines supply from pharmacy was available and staff knew the routes to obtain medicines out of hours if required. However, the PDU had no pharmacy services cover. Although staff on the ward knew how to escalate concerns to pharmacy, this took time. We were told that although patients were meant to arrive on the PDU with their medicines ready for discharge this did not always happen. Some patients arrived with no discharge summary and had to wait for their medicines to be prescribed and then dispensed. This meant there were delays in the discharge of patients.

Staff did not always review 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. However, as there was no clinical pharmacy service within the PDU and due to a lack of medical support, there were no medicine reviews or clinical checks on prescribing and no medicine advice or support to staff, patients or carers.

Staff completed medicines records accurately and kept them up-to-date. Staff recorded allergy statuses of patients in all medicine records seen, on PDU and all other wards, meaning that allergies were highlighted, and medicines could be prescribed safely. Staff recorded patient weights on medicine administration records which is important for calculating weight-based medicines prescribing. VTE risk assessment outcomes and prescribing were completed on all patients notes reviewed at admission.

Staff mostly stored and managed all medicines and prescribing documents safely. Medicines were stored neatly and tidily on PDU in dedicated secure storage areas with access restricted to authorised staff. Emergency medicines and equipment were available and expiry dates checked were in date. They had 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.

Medicine fridges were locked and secure with authorised staff access only. Staff recorded medicine fridge temperatures daily and were within a safe range for medicine storage. On Laurel 3 ward, chemotherapy drugs were stored in a separate fridge to other drugs.

On MAU, we saw an oxygen cylinder holder with 8 portable oxygen cylinders in. Cylinders which were almost empty were mixed in with cylinders that were almost full. When a staff member was asked about this, they said that when porters come to change the cylinders, they sort through the cylinders and change as needed. Empty cylinders should not be stored with usable cylinders as they can be selected in error and fail in use.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff recorded medicines history on admission and medicine reconciliation was undertaken following national guidance. However, due to the lack of clinical support in the PDU medicines were not always checked as appropriate before the patient was discharged.

Staff learned from safety alerts and incidents to improve practice. 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.

The trust had a medicines safety officer (MSO) in line with NHSE directives. The MSO investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents. Any learning was shared via newsletters or posters.

Incidents

The service generally managed patient safety incidents well. Staff recognised and mostly reported incidents and near misses, although sometimes they felt they were too busy to do so. Managers mostly investigated incidents and shared lessons learned with the whole team and the wider service, although less so on some units. 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.

All staff knew what incidents to report and how to report them. All staff we spoke to knew how to report incidents via the DATIX system. Staff could give examples of incidents that they had reported such as patient falls, a patient developing a pressure ulcer, and the transfer of patients onto Discharge Lounge and the PDU outside of the units' SOP.

Staff generally raised concerns and report incidents and near misses in line with trust/provider policy. Although all staff members understood how to report incident and near misses, 2 members of staff told us that they did not always have time to complete incident reports. A member of staff said they delegated incident reporting to a colleague if they were too busy.

The service had no never events on any wards. No never events were reported for the medicine specialty at Worcestershire Royal Hospital between 21 November 2021 and 22 November 2022.

Managers shared learning with their staff about never events that happened elsewhere. Although there were no never events on medical wards, senior managers shared lessons learned from never events on surgical wards and theatre with staff across the trust in 'Learning from Serious Incidents', a weekly bulletin.

Medical care (including older people's care)

Staff reported serious incidents clearly and in line with trust policy. Between 21 November 2021 and 22 November 2022, staff reported 73 serious incidents relating to the medicine specialty at the Worcestershire Acute Hospitals NHS Trust via the Strategic Executive Information System (StEIS). Of the 73 serious incidents reported, 55 related to either COVID-19 outbreaks on wards, or the inclusion of COVID-19 as a contributing cause of death on a patient's death certificate.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Most staff we spoke to understood the principles of Duty of Candour, and we saw evidence that Duty of Candour had been applied in the incident reports reviewed.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff told us that they did not always personally receive updates and feedback on incidents that they had reported, but that incidents were discussed at staff 'huddles' and team meetings.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback.

We reviewed a sample of minutes from Mortality and Morbidity meetings for several medical specialties. In a case discussed in the Stroke meeting, a lack of timely imaging may have impacted upon the subsequent treatment the patient received. As a result, it was agreed that the Stroke consultant on-call over the weekend would see all stroke referrals in the emergency department (ED) to ensure that all relevant imaging had been considered and requested to ensure the most appropriate treatment.

Managers mostly investigated incidents. Patients and their families were involved in these investigations. However, this was not always the case on Discharge Lounge and PDU.

We reviewed a sample of 10 recent incident reports across medical specialty wards. We also reviewed all incident reports from Discharge Lounge and PDU from 25 August to 25 November 2022, as staff from these units particularly told us that they did not receive feedback from incidents that they had reported.

Of the 10 incident reports reviewed from across medical specialty wards, a manager's response and actions completed had been documented for all 10. One incident was classed as a serious incident, and we reviewed an initial case review for this incident. There was evidence in the case review that an apology had been given to the patient, and that the final report was to be shared with the patient and their family in line with the duty of candour.

On Discharge Lounge, staff reported 48 incidents between 25 August and 25 November 2022. Of the 48 incidents reported, managers had investigated 6. In the same period, staff reported 60 incidents regarding PDU. Of the 60 incidents reported, managers investigated 20. The trust told us that they recognised that there had been delays in responding to incidents, and that this was due to staff sickness and absence. Since the inspection, a designated matron was put in place to oversee reporting and feedback. The trust told us that all outstanding and overdue incidents and complaints had been investigated and closed, all complainants contacted individually, and that concerns had been responded to with associated actions.

Is the service effective?

Good 

Medical care (including older people's care)

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff told us that trust policies and national guidelines such as National Institute for Health and Care Excellence (NICE) guidance were easily accessible on the trust intranet site. We reviewed 4 trust policies and found them to be in date and version controlled. Standard operating procedures (SOPs) were in place for endoscopy and in date.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Generally clinical practice reflected guidance and best practice. Key issues in patient care were handed over and discussed with a multidisciplinary team where relevant.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed a handover on Medical Assessment Unit (MAU). For patients on an end of life pathway, recommendations for communication with the families was discussed.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. All the patients we spoke to said that they had enough to eat and drink. A patient who could not eat red meat said they had plenty of alternative choices to meet their needs. Another patient was very pleased that they were provided with their favourite drink. One patient however said that they did not feel they always got their recommended 5 portions of fruit and vegetables a day from the food choices on offer. Staff ensured that drinks were in patients' reach during intentional care and comfort rounds. Cold snacks such as cheese and biscuits were available for patients outside of mealtimes. We observed a lunch service on Acute Respiratory Unit. When a bell sounded at 11:50am, 7 nursing staff members lined up by the catering trolley with food trays and patient menu choices, ensuring that the service was prompt and organised. Staff told us that they encouraged patients to feed themselves, but where patients needed support to eat, their meals were served on a red tray to help staff identify this need.

The trust scored 81.81% for food and hydration in the latest Patient-Led Assessment of the Care Environment data available from 2019. The national average in this domain was 92.19%.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. They were present and complete in all 10 of the records reviewed. Staff also completed patient stool charts.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used MUST, the malnutrition universal screening tool.

Medical care (including older people's care)

Specialist support from staff such as dietitians and speech and language therapists was mostly available for patients who needed it. On all base wards, we saw evidence of dietitian and speech and language therapy input in patients' records. There were no funded dietetic or speech and language services on Pathway Decisions Unit (PDU) however, as the unit was intended for patients who had been discharged from therapy services.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, but patients were generally given pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff asked patients if they had any pain as part of 2 to 4-hourly intentional care and comfort rounds. All the patients we spoke to who had needed pain relief said that it was sufficient, and that staff were responsive to their needs. Staff used the Abbey Pain Scale for patients unable to verbalise their pain levels.

Patients received pain relief soon after requesting it. All of the patients we spoke to who had requested pain relief said it was given in a timely manner.

Staff prescribed, administered and recorded pain relief accurately. This was evident in the patient records reviewed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. This included Sentinel Stroke National Audit Programme (SSNAP), National Audit of Inpatient Falls (NAIF), National Asthma and COPD Programme (NACAP) Audit, National Acute Kidney Injury Audit and the National Lung Cancer Audit.

Outcomes for patients were mixed, inconsistent and did not always meet expectations, such as national standards.

The latest SSNAP report, which covers patients admitted and discharged between April and June 2022, gave stroke care an overall SSNAP level of 'B'. This is the second highest level in a scoring system ranging from 'A' to 'E'. The audit covers 10 key performance indicators (KPIs) including physiotherapy input, occupational therapy input, speech and language therapy input and discharge processes, for which the service received an 'A' score, meeting or exceeding national averages. The service scored 'E' for the stroke unit key performance indicator however. The percentage of patients directly admitted to a stroke unit within 4 hours, and the percentage of patients who spent at least 90% of their hospital stay on a specialist stroke unit were significantly below the national average. During our inspection demand for beds on Acute Stroke Unit (ASU) far outweighed capacity. While 1 patient was ready for discharge, 4 patients required admission from home or the Medical Assessment Unit (MAU), and a further 4 patients required Stroke Consultant review in the Emergency Department. In addition, 3 patients were awaiting transfer to the unit from the Alexandra Hospital. The service scored 'D' for the thrombolysis KPI. The percentage of eligible patients given thrombolysis was 43.9%, versus the national average of 83.7%.

Medical care (including older people's care)

Results from the NACAP COPD audit report for patients discharged between 1 October 2021 and March 2022 showed performance was better than the national average in 3 of the 6 KPIs. Performance was below the national average in 1 KPI regarding current smokers being prescribed a stop smoking drug or referred for behavioural intervention for smoking cessation. This score was 32% versus the national average of 56%.

Outcomes for patients in the trust in latest National Lung Cancer Audit results from 2019 were generally in line with, or just below national averages. 69.4% of patients were assessed by a specialist nurse, exactly in line with the England average. The proportion of all lung cancer patients who had anti-cancer treatment was 58.8%, compared to the England average of 58.5%. However, the proportion of patients with stage 1 or 2 disease who received treatment with curative intent was 69.8%, lower than the national average of 80.8%. Overall survival rate was 36.9%, just below the national average of 38.7%

We reviewed the latest NAIF by the Royal College of Physicians which assessed aspects of falls prevention and post-fall care. This included whether a high-quality multi-factorial risk assessment was performed before the fall, and whether staff adhered to NICE QS86 in their post-fall management. The trust scored above the national average on components of the multi-factorial risk assessment including whether the patient had had a lying/standing blood pressure taken (100%), a mobility assessment done (100%) and a complete delirium assessment (86%). The score for continence assessment was 32% however, significantly below the national average of 83%. Scores for checking injury before moving patients after a fall, and the use of flat lifting equipment to lift the patient were significantly above the national average. The third element of post-fall management however, medical assessment within 30 minutes, was below the national average at 57% versus 69% nationally.

Results from the latest National Acute Kidney Injury Audit in 2020 showed that staff recorded episodes of acute kidney injury accurately and completely.

Managers and staff did not always use the results to improve patients' outcomes.

Staff produced a SSNAP action plan. There was evidence of measures in place or in progress to improve flow through the stroke service, such as daily liaison with the local community NHS trust, to co-ordinate flow to rehabilitation services, and a plan to recruit a full time coordinator to work across the stroke pathway to facilitate patient flow. However, there were no specific actions regarding referral or access to thrombolysis documented.

Staff wrote an action plan following the NACAP COPD audit. However, this plan did not include an action for smoking cessation, the KPI where the centre was below the national average.

The service had an expected risk of readmission comparable to the national average. Data from September 2021 to August 2022 showed that the 30-day emergency readmission rate for the Worcestershire Acute Hospitals NHS Trust was 8.31%. This is just above the national average of 8.16%, and below the Midlands average of 9.32%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Senior nursing staff carried out weekly nursing quality audits across medical wards which included environmental checks, such as availability of personal protective equipment (PPE), staff adherence to trust uniform policy, and patient quality checks such as the patient being appropriately clothed, having access to their call bell, and being aware of who was looking after them that day. Where results were non-compliant, a system-generated email was sent to the ward manager. Staff also carried out audits on National Early Warning Scores (NEWS), records, infection prevention and control and sepsis.

Pharmacists carried out quarterly antimicrobial audits including checks such as documentation of drug allergy status and 72-hour clinician review. They also carried out controlled drug audits, and annual Safe and Secure Handling of Medicines audits.

Doctors recently started completing a monthly venous thromboembolism (VTE) inpatient audit, identifying if VTE assessments have been completed, if the interventions on assessments have been transcribed onto the drug chart, and if the drug chart evidences administration of those interventions. Junior doctors also aimed to carry out 10 “Start Smart Then Focus” self-audits per month to promote antimicrobial stewardship.

Managers used information from the audits to improve care and treatment. Managers reviewed local audit results and themes and added actions to the division’s action tracker spreadsheet. They discussed any outstanding or overdue action at weekly Divisional Governance Meetings.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. We reviewed monthly NEWS audits for September, October and November 2022. Although compliance with recording patient observations and correctly calculating NEWS was generally high across the wards, where there were incorrectly calculated scores on 1 ward, the manager investigated these issues, identified the staff responsible and addressed them at the time. The Ward Manager also increased the number of patients audited going forward to further monitor compliance.

We also reviewed sepsis audits for July, August and September 2022. Where compliance with the Sepsis 6 had fallen in September, there was evidence that this drop had been acknowledged and investigated by managers, and action plan formed. A poorly performing ward was highlighted as requiring further support and guidance, and so personalised training for all staff on that ward was included in the action plan.

Managers shared and made sure staff understood information from the audits. Staff told us that audit results were discussed in staff meetings and ‘huddles’. We also saw that actions put in place following September’s drop in sepsis audit results included discussion in the Sepsis Link Nurse meeting, and circulation in the next Sepsis newsletter to ensure staff were fully informed.

Improvement is checked and monitored. Where managers had placed audit outliers on the action tracker spreadsheet, there was evidence that compliance was monitored for improvement, and actions closed when improvement was achieved.

The endoscopy service was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. This generally lasted for 2 weeks and included completing all mandatory training relevant to the role. Staff on Laurel 3 ward told us that all new staff were supernumerary during their induction period.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data received after the inspection showed that 80.96% of speciality medicine staff including nursing, administrative and clerical and therapy staff had received an appraisal within the past year. 93% of staff in endoscopy had received an appraisal, and this figure was 94.12% in haematology, oncology and palliative care.

On average, 97.32% of specialty medicine medical staff who were eligible for an appraisal had had one in the past year. For consultants, this figure was 100%. We did not receive data on appraisals for medical staff in endoscopy or haematology, oncology and palliative care.

The clinical educators supported the learning and development needs of staff. A student nurse we spoke to was complimentary about the support she was given by staff to achieve clinical proficiencies.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff we spoke with told us they felt the meetings were useful and a way to share information.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. A healthcare assistant (HCA) who had worked in the service for less than a year told us that they had been given the opportunity to train as a moving and handling instructor since joining. They have also been signed up to a course on venepuncture.

Managers made sure staff received any specialist training for their role. Staff in endoscopy had specialist training for their role, including support staff who received specific training on scope cleaning. Staff on Laurel 2 ward told us that that registered Nurses undertook a specialist oncology course, and HCAs on the ward also had enhanced training for oncology.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers fulfilled several roles in the service including way finders, ward volunteers, chaplaincy volunteers, volunteer administrators and membership of the Patient and Public Forum. Managers ensured that volunteers received a trust induction and a local induction to the area that they are placed, for example on a ward. Volunteers completed core e-learning training modules, and additional training relevant to role. Managers tracked compliance via a dedicated Volunteer App.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Several staff commented on the effectiveness of the multidisciplinary team, and we saw evidence of multidisciplinary input in all the patient records we reviewed.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Ward staff told us that they had nominated link nurses for specialities such as infection prevention and control and diabetes who attended relevant meetings and shared updates with their teams.

Staff on Laurel 3 haematology and Laurel 2 oncology wards told us that they had strong links with the palliative care team who visited the wards daily for patients requiring input for end-of-life care and pain management. They also told us that they had good links with 2 local hospices.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants. We saw evidence of timely consultant review in the records reviewed.

7-day services

Key services were available 7 days a week to support timely patient care.

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. Staff told us that they could request laboratory tests and imaging 24 hours a day, 7 days a week, and that results were generally returned quickly. Staff told us they could access support from pharmacy either from designated ward pharmacists, or via bleep where there was not a pharmacist for that ward. Staff commented that they were “excellent” and “very supportive”, although several staff told us they were concerned that a lot of pharmacy staff had recently left the service.

Staff on Laurel 2 told us that the availability of the acute oncology service had recently gone from 5 to 7 days a week. Staff on Acute Stroke Ward (ASU) told us that they had 24/7 access to thrombolysis services on site.

Although endoscopy was not a fully staffed service 24 hours a day, there was an on-call system. Staff told us that this was being monitored and reviewed however, as they could be called in up to 30 times over a month.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw several examples of health promotion. A display on PDU on ‘Strength and Balance’ explained the benefits of exercise and gave pictorial information about some prescribed exercises. There was another display on PDU called ‘Dressed is Best’, encouraging patients to get dressed in their own clothes and get moving to encourage a speedier recovery. On Avon 4 ward many leaflets were available to patients and their relatives including information on local dementia cafes, and dementia advice for carers.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff on Laurel 3 ward told us that they had an exercise bike that could be put into a patient’s room to use if requested.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us that they gained verbal consent for routine care and treatment and understood when written consent would be necessary.

Medical care (including older people's care)

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Patients said staff were very explanatory and answered any questions they had about their treatment.

Staff clearly recorded consent in the patients' records. We saw evidence of consent in the patient records reviewed.

Nursing staff received and generally kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Nursing staff in specialty medicine across the Worcestershire Royal and Alexandra Hospital sites were 81.35% up to date in this training. In haematology, oncology and palliative care 77.78% of nursing staff were up to date. In endoscopy, 90% of nursing staff were up to date with Mental Capacity Act and Deprivation of Liberty training, in line with the trust target of 90%.

Medical staff received but did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Medical staff in specialty medicine across the Worcestershire Royal and Alexandra Hospital sites were 45.75% up to date in this training. In haematology, oncology and palliative care 56.25% of medical staff were up to date with training. In endoscopy however, 100% of medical staff were up to date with training, although this data set consisted of 1 person.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew how to access relevant policies. A member of nursing staff told us that they would raise any concerns they had to a doctor. A member of medical staff said they would get advice from their consultants around the Mental Capacity Act and Deprivation of Liberty Safeguards if needed.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. A patient on Acute Stroke Unit told us that they appreciated the support that staff gave them, and that they spoke to them quietly and calmly.

Patients mostly said staff treated them well and with kindness. Most patients we spoke to said that staff introduced themselves before treating them and found staff to be friendly and polite. Two patients were concerned about agency staff however, with 1 patient saying that they "vary considerably, some are brilliant, some are rude".

Staff mostly followed policy to keep patient care and treatment confidential. All the patients we spoke to said they felt their privacy, dignity and confidentiality were maintained at all times. Handovers on Medical Assessment Unit (MAU) were carried out in non-clinical areas so that personal information about patients could not be overheard. However, on Discharge Lounge there was a whiteboard behind the nurse's station with sensitive patient information such as dementia and resuscitation status on which was visible to the clinical area.

The trust scored 78.95% for privacy, dignity and wellbeing in the latest Patient-Led Assessment of the Care Environment data available from 2019. This was lower than the national average of 86.09%.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw posters on Acute Stroke Unit promoting visits from a therapy dog on Saturdays. Staff we spoke to said that the visits provided an emotional boost to patients and staff alike.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Endoscopy staff we spoke to said that if a patient has not had sedation as part of the procedure, bad news was often given on the same day. This was done in a separate room with relatives and a Nurse Specialist present. Staff would give patients a plan of what would happen next and had leaflets available for them to read. Staff on Laurel 2 ward told us that they use the relatives' room at the end of the ward when having sensitive conversations with patients and families.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure patients and those close to them understood their care and treatment. Most patients we spoke to said that they and their families were kept informed and up to date with their treatment plans. A patient said staff on the ward explained things well, and another said they could always ask staff any questions they had. A patient we spoke

to in the Discharge Lounge however said that they did not see a doctor before being taken from the ward and was unsure about the plan going forward as they felt like the decision to discharge was very rushed. Another patient said that they were not told how long they would be waiting in Discharge Lounge and said that communication could be improved in this regard.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

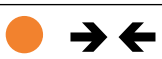
Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Posters for the Patient Advisory and Liaison Service were displayed in clinical areas encouraging patients to give feedback on their care.

Staff supported patients to make advanced decisions about their care. Staff used AMBER care bundles to help patients whose recovery was uncertain to make advanced decisions about their care. Appropriate completion of the bundle, and whether it had been discussed with the patient's family and next of kin, was audited as part of the weekly nursing quality audit.

Staff supported patients to make informed decisions about their care.

Patients generally gave positive feedback about the service. Friends and Family survey results for October 2022 were generally positive. There was 1 outlier in the data, Discharge Lounge, with a recommendation rate of 50%, although this was based on 2 reported responses. The remaining responses ranged from 85.71% to 100% of patients who would recommend the service to friends and family. We saw many examples of thank you cards from patients on display on wards and cards and chocolates from patients in staff break areas. Staff on Acute Stroke Unit spoke about a picture on the ward that a relative had painted and donated to them in thanks for the care the patient received.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, the Discharge Lounge and Pathway Decisions Unit (PDU) were not always meeting patients' needs. It also worked with others in the wider system and local organisations to plan care.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The endoscopy unit had separate areas for male and female patients to enable them to do mixed sex lists.

Medical care (including older people's care)

Facilities and premises were generally appropriate for the services being delivered. However, services were being delivered on Discharge Lounge and PDU that the facilities were not intended for. Discharge Lounge was in a remote location in the hospital which made timely access to medical support difficult. Since the inspection however, Discharge Lounge has been relocated to a new area, and a 'fit to sit' model implemented, mitigating the risks posed by bedding patients overnight.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service did not always have systems to help care for patients in need of additional support or specialist intervention. Staff we spoke to on PDU told us they felt that not having funded therapy input was detrimental to the care of patients on the unit, in particular those awaiting a rehabilitation pathway who were at risk of deterioration. We reviewed DATIX reports from PDU and saw several reports relating to patients needing additional therapy support which, in 1 case, delayed their discharge compared to if they had stayed on their base ward where support was readily available.

The service relieved pressure on other departments when they could treat patients in a day. We spoke to a clinical nurse specialist on Acute Respiratory Unit who ran a pleural effusion service, inserting chest drains. They stated that alongside booked patient clinics, they went into the emergency department to identify people that they could treat within their clinic as an outpatient, rather than a patient being admitted. They reported that they had completed relevant competencies to do this, followed the WHO 5 steps to safety surgery checklist, and collected clinical outcome data such as complication rates for each patient.

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. Staff assessed all patients over 65 years old for dementia and delirium, and if applicable, a Dementia/Delirium Care Bundle was put in place. This was audited weekly as part of the Nursing Quality audit, and compliance was consistently high.

Ward staff told us that they had nominated learning disability link nurses who attended meetings and shared updates with the rest of the team. Staff we spoke to in endoscopy told us that they supported patients with learning difficulties by having carers present on the unit and providing them with side rooms if needed. Staff also told us that diabetic patients and children would be first on the procedure list.

The trust scored 75.59% in the disability domain in the latest Patient-Led Assessment of the Care Environment (PLACE) data available from 2019.

Wards were generally designed to meet the needs of patients living with dementia. The trust scored 73.5% in the dementia domain in the latest PLACE data available from 2019. This looked at aspects of the ward such as flooring, fixtures and fittings, particularly that they are of contrasting colour to the area around them, signage and the avoidance of strong patterns in wall coverings and bedding, for example, to avoid sensory overload. This score was a little below the national average of 80.7%.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Where applicable, patients had a 'This is Me' document and dementia care bundle in their notes.

The service did not have information leaflets available in languages spoken by the patients and local community. We did not see any evidence of literature in languages other than English.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw a poster on Medical Assessment Unit (MAU) with instructions for staff on how to book a face-to-face interpreter via an app, and the number for a telephone interpreter service should they be needed urgently. The poster also had advice on how to best communicate with deaf patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us that there was always a vegetarian option on the menu to help meet patients' cultural and religious preferences.

Access and flow

People could generally access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were generally in line or just above national averages. Discharges were at times delayed.

Managers monitored waiting times and made sure patients generally received treatment within agreed timeframes and national targets.

The latest referral to treatment data from November 2022 showed that the proportion of patients within the medicine specialities in the trust treated as inpatients within 18 weeks of referral was on par with the national average. The proportion of patients treated as outpatients within 18 weeks in the trust was slightly lower than the national average, at 64% versus the national average of 68.9%.

Waiting times for endoscopy were roughly in line with the national average. In November 2022, 40.6% of patients waited more than 6 weeks for their procedure versus the national average of 37.9%. Fewer patients in the trust waited more than 13 weeks for endoscopy however versus the national average.

We reviewed cancer waiting times in the trust against the national target of 93% of patients seeing a specialist within 2 weeks of an urgent GP referral. In November 2022 75.6% of patients saw a specialist within this timeframe, significantly below the national target, and below the Midlands average of 82.6%. The trust performed better than the Midlands average in the proportion of patients treated within 31 days of a decision to treat however, at 93.2% versus the Midlands average of 87.2%. The national target was 96%.

Managers and staff worked to make sure patients did not stay longer than they needed to, although some delays occurred. At the time of the inspection, a continuous flow model had been operating for approximately 2 months. The aim of this was to increase capacity and flow throughout the hospital, from the Emergency Department (ED) to discharge. From 6am, 2 patients per hour were moved from the ED onto MAU and base wards. A capacity and flow team led by the director of capacity and flow held bed meetings via teleconference 3 times a day to review flow and bed availability across the Worcestershire Royal and Alexandra Hospital sites.

Managers worked to the 5 elements of the SAFER patient flow bundle which were;

S – Senior review**.** All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and no unnecessary waiting.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – Early discharge. Thirty three percent of patients will be discharged from base inpatient wards before midday.

R – Review**.** A multi-disciplinary team review of patient's lengths of stay of more than 7 days with a 'home first' mind-set.

Patients who were deemed medically fit for discharge could be moved onto Discharge Lounge, or if awaiting further rehabilitation or a package of care, Pathway Decisions Unit (PDU). There were 3 pathways on PDU. Pathway 1 was for patients going back to their usual place of residence with a package of care in place, pathway 2 was for patients waiting for rehabilitation beds in the community, and pathway 3 was for patients awaiting care home placements. Key performance indicators for PDU aimed for a maximum length of stay 24 hours for patients on pathway 1, 48 hours for patients on pathway 2 and 72 hours for patients on pathway 3. Data showed that since the opening of PDU in July 2022, the average length of stay for all patients was steadily increasing. In July 2022, the average length of stay on PDU was 57.9 hours whereas in November 2022 it was 77.3 hours, longer than the KPI for all pathways. In the same period the average length of stay on Discharge Lounge did decrease however, from 14.8 hours in July 2022 to 10.8 hours in November 2022.

We spoke to the director of capacity and flow about what the challenges to ensuring patients did not stay longer than they needed to were. They said that due to capacity issues faced by care homes, patients on this pathway often waited longer than necessary to be discharged from hospital once medically fit. They also said that discharge to care homes was problematic over the weekend, as staff from homes were not always available to review the patient before agreeing to admit them, meaning they would have to wait until Monday. They also highlighted that since the COVID-19 pandemic, the service no longer has specifically commissioned rehabilitation beds in the community for patients on a stroke or fractured neck of femur pathway, which can also be a source of delays for pathway 2 patients. Furthermore, patients waiting for out of area repatriations could also be in hospital longer than necessary. Staff on Discharge Lounge told us that the main barriers to a timely discharge were patients waiting for electronic discharge summaries which had not yet been completed by doctors, and for Tablets to Take Out to be dispensed.

The service did not always move patients only when there was a clear medical reason or in their best interest. However, they provided explanations to patients as to why. Bed capacity had been increased on wards as part of the continuous flow model, with the ability to have 37 patients 'boarding' at a time, generally in an extra bed in the middle of a bay or on a ward corridor. On 23 November, there were 12 medical patients boarding. The director of capacity and flow explained that each morning a list of patients who had been clinically assessed on wards as suitable for 'reverse boarding' was drawn up. This meant patients who would potentially be moved out of their bed space onto a corridor to give their bed to a sicker patient from MAU. We spoke to a patient on Acute Respiratory Unit who had been moved out of their bed into a chair before they were to be discharged to make way for a patient being transferred onto the ward. They were given a letter to explain why this was happening however and understood that a sick patient required their bed. They reported receiving good care on the ward.

Staff did not always avoid moving patients between wards and discharging at night. We saw an example of an incident report where an elderly patient with metastatic cancer had been discharged to a community hospital at 2am.

Managers and staff started planning each patient's discharge as early as possible. This was in line with the 'A' of the SAFER patient flow bundle.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. This was discussed during capacity and flow meetings.

Staff supported patients when they were referred or transferred between services.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. A medical outlier doctor was in place to provide cover.

Managers worked to minimise the number of medical patients on non-medical wards. However, this could not always be prevented in times of increased pressure on capacity.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. All the patients we spoke to said they knew how to make a complaint if it was necessary.

The service clearly displayed information about how to raise a concern in patient areas. All areas of the service displayed contact details for the Patient Advice and Liaison Service in patient areas should they wish to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would try to solve the complaint themselves first if it was within their ability. They said that if they could not solve the problem, they would escalate the complaint to a more senior member of staff.

Managers investigated complaints and identified themes. We reviewed a sample of 10 formal complaints from the last 6 months from across the trust. There was evidence that managers investigated complaints and identified the root causes. In 7 of the 10 complaints reviewed, communication was a major theme identified. Managers produced action plans to be completed by a set due date, and in general actions had been completed on time.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We also saw a noticeboard in the staff room of Avon 4 with learning prompts from complaints on, such as "please ensure curtains are closed when assisting patients with personal care".

Staff could give examples of how they used patient feedback to improve daily practice. On several wards we saw "You Said, We Did" noticeboards, highlighting patient feedback and how this was used to improve the service. An example from Patient Discharge Unit was "You said you needed help with soup at lunchtime, so we found you a beaker to help you eat".

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

The medicine service was 1 of 4 services overseen by the trust board. Medicine was divided into the Urgent Care and Specialty Medicine divisions, and each division was overseen by a Divisional Director of Operations, Divisional Director of Nursing and Divisional Director. Medical wards had a ward manager who was supported by matrons.

At the time of inspection, the operational management of the Discharge Lounge was the responsibility of the clinical site management team, and performance of Discharge Lounge was overseen by the director of capacity and flow. However, since the inspection, management has been transitioned to Specialty Medicine, and a Directorate Manager and matron have been allocated to oversee the operational and quality and safety management of the Discharge Lounge. We interviewed the director of capacity and flow who oversaw patient flow throughout the hospital, from the Emergency Department to discharge, as part of the inspection. They demonstrated good understanding and knowledge of operational matters and were receptive to our feedback. Although endoscopy came under the specialised clinical services division, we inspected this service as part of our medical care methodology, and therefore have included this in our report.

The ward managers and matrons we spoke with on the wards we visited were visible and engaging and had good knowledge of operational matters and the patients on their wards. We heard example of leaders supporting staff to develop their skills. We spoke to a ward manager who was new in post who told us that their matron had been very supportive in their development in the role. Managers also told us that in order to encourage recruitment and retention of HCAs, they are looking to further develop the role, giving staff the opportunity to train in additional skills and achieve a higher banding. Some of the medical staff we spoke to said that leaders were not always visible in the service. A doctor remarked that they had never seen senior management, and another stated that senior leaders were only visible when the Emergency Department was at full capacity.

Leaders understood the challenges to quality and sustainability. The challenges they identified included hospital patient flow, increased numbers of medical outliers within the service and staffing. Senior members of staff had the skills and experience to run the service.

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.

The trust had the ‘4ward’ vision and strategy. The vision was “working in partnership to provide the best healthcare for our communities, leading and supporting our teams to move 4ward”. Their strategic objectives were;

Medical care (including older people's care)

Best services for local people

Best experience of care and outcomes for our patients

Best use of resources

Best use of people

Their enabling strategies were clearly presented and consisted of Quality Improvement, People and Culture, Estates, Digital, Medium Term Financial Plan and Communications.

The trust promoted 4 '4ward' signature behaviours in staff which were;

Do what we say we'll do

No delays, every day

We listen, we learn, we lead

Work together, celebrate together

The staff we spoke to about the trust's vision and strategy were aware of it and knew where to access more information about it. The Trust had a group of over 300 staff '4ward advocates'. The aim of the group was to support and embed the '4ward' signature behaviours and provide 'ward to board' feedback from their colleagues to the Executive Team and Board.

Culture

Staff did not always feel 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 largely had an open culture where patients, their families and staff could raise concerns without fear, although some staff felt concerns were not always addressed.

Staff we spoke to did not always feel supported and valued by the service, although many staff reported that they felt more supported by their immediate teams and line managers. For example, a staff member we spoke to on Avon 4 ward said that everyone on the ward helped each other out to care for patients. Staff on Laurel wards also felt supported and described good teamwork between Laurel 2 and 3. However, morale was low in some staff. A foundation year doctor we spoke to said they felt "like a number", and were not able to use all the skills that they had been trained in. A member of staff on Medical Assessment Unit (MAU) said they felt under extra pressure and overstretched since the ward had moved and the number of beds had increased. Another doctor we spoke to said they sometimes went a whole night shift without a break as the work was "relentless". In the latest staff survey for speciality medicine, staff scored their morale as 5.8 out of 10, and 'we are recognised and rewarded' as 5.9 out of 10. Staff scored 'we are a team' 6.8 out of 10 however, and 'we are compassionate and inclusive' scored 7.3 out of 10.

The trust had an Equalities Engagement Lead, and all staff completed mandatory Equality and Diversity training. There was an active Lesbian, Gay, Bisexual, Transgender, Questioning + (LGBTQ+) Network, with a page on the website dedicated to sharing strategies for, and asking for suggestions as to how the service can be more inclusive for patients from the LGBTQ+ community. The trust had annual staff awards and long service awards, and on 1 of the inspection

days, the service celebrated 'HCA Appreciation Day', where ward managers presented HCAs with a certificate, travel mug, keyring and pen as a token of thanks. On MAU, we saw posters signposting staff to the Staff Mental Health and Wellbeing Hub and a telephone number for a free counselling service. Some staff were aware that there was a lead Wellbeing Nurse, although a member of staff remarked that they did not have time to engage with them.

Staff largely said that they could raise concerns without fear, although they felt they were not always addressed. Staff were aware of the Freedom to Speak Up Guardian and we saw posters promoting the Freedom to Speak Up service in staff break rooms. All the patients we spoke to said that they would feel able to raise a concern themselves, or via a family member, without fear.

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 places to assess, monitor and improve the quality of care within medicine, and staff met regularly to discuss service performance. Ward managers held regular staff meetings and ensured that minutes were circulated for those staff who could not attend. Staff were encouraged to participate in governance activity, for example, on PDU, a different named band 6 nurse was responsible for carrying out nursing quality audits each week. Link nurses, for example in infection prevention and control and learning disabilities, attended meetings for their respective specialities and shared learning with their wards.

Weekly Divisional Governance meetings reviewed performance, audits, incidents and complaints. Each specialty in the division held monthly Mortality and Morbidity meetings, where aspects of care which fell below expectations were discussed and actions formulated. Cases highlighting good practice were also shared. Serious incidents were investigated, and action plans made within the Serious Incident Review and Learning Group.

A review of Board Meeting papers showed appraisal of operational performance with associated actions at executive level.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events.

The service used a programme of repeated local audits to monitor performance, and had systems in place to effectively manage outliers, and improve performance. The same systems were not in place for national audits however, as action plans we reviewed did not always address outliers.

We saw, and staff told us about, renewed focus on some areas of poor performance reported during our last inspection, such as the timely completion of Sepsis 6 bundles. However, other areas of poor performance, such as the completion of mandatory training including safeguarding training by medical staff, and the completion of Mental Capacity Act and Deprivation of Liberty Safeguarding training, had not been rectified at the time of this inspection.

The service had a risk register in place to help identify and manage areas of risk. However, the omission of patients admitted to Discharge Lounge and PDU against SOPs on the risk register until after the inspection suggests a lack of oversight of the risks. We were not assured that a robust system was in place for mitigating risks when patients were admitted onto Discharge Lounge and PDU outside of inclusion criteria.

We were assured that the service had plans in place to cope with unexpected events, such as major incidents.

Information Management

The service collected reliable data and analysed it. Staff could generally find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff accessed patient information in paper notes and on electronic systems. Paper records we reviewed were generally comprehensive, legible and easily accessible. Some staff we spoke to, particularly doctors, felt that there were not enough computers in the service, and this led to time being wasted waiting to access the information they required from the electronic systems. A doctor also commented that there were too many individual information systems related to patient care, and this was inefficient.

Staff and managers used the Worcestershire Reporting Network, known as 'WREN', application to submit and view audit data, and staff we spoke to referred to it positively.

There were effective arrangements to ensure that externally required data and notifications were reliable and submitted in a timely way.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The Chief Executive held monthly 'Meet the Chief' drop-in sessions where staff members could discuss key issues. The trust had a social media account with over 5,000 staff as members.

Leaders engaged with patients and the public via the Patient Experience and Patient Public Forum (PPF). Leaders consulted the PPF on the development of quality improvement and clinical services strategies. The PPF also participated in assurance programmes such as safety walkarounds, audits on mixed sex breaches and care in the corridor, and supported staff in undertaking Patient Led Assessments of Care Environment (PLACE). The service gathered patient views via text messaging, asking for a review of the service upon discharge.

The service regularly collaborated with the Integrated Care Board, particularly to help facilitate patient flow into the community.

Learning, continuous improvement and innovation

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

Medical care (including older people's care)

The trust had the Path to Platinum quality improvement programme in place, where wards worked through 4 levels of accreditation, Bronze, Silver, Gold and Platinum. Results of the Nursing Quality audit fed into the programme. The trust had dedicated teams to support staff in quality improvement, including a Quality Improvement Matron.

We saw evidence of innovation. On Avon 4 ward, staff were trialling Ramblegard, sensor mats that were placed in the beds of patients at high risk of falls. The system would alarm if the sensor was triggered by the patient getting out of bed unassisted. Staff we spoke to said the trial had so far produced good outcomes. PDU were also trialling a 2-week rolling menu to improve the efficiency of the service.

Urgent and emergency services

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

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

Mandatory training rates were recovering following problems accessing the courses during the pandemic. All those staff requiring training were being booked on to courses and this was being monitored by managers. Most of the shortfall was refresher training; all new starters were prioritised and so all staff had received training. This was confirmed by the new starters we spoke to.

Month by month mandatory training rates for medical and nursing staff were displayed on staff noticeboards for information and as an incentive to get the highest scores. We saw that the mandatory training being below the trust target was highlighted in various governance reports and discussed in the management meetings.

Nursing staff received and mostly kept up-to-date with their mandatory training. Mandatory training rates for nursing staff were mostly between 80% and 95% against the trust target of 90% with an average of 86%. Of the 19 modules 7 met the target, 9 were 80 to 90%, and 3 were less than 80%. Resuscitation training was notably low with level 1 at 57% and level 2 at 73%. Safeguarding level 3 training was 33% representing 2 nurses trained out of the 6 that required this level of training.

All nursing staff had to be compliant with different levels of life support training depending on their banding or level. For basic life support (BLS) the rate was 88%, for intermediate life support (ILS) 91% and for paediatric intermediate life support (PILS) 73%.

Medical staff received but did not keep up-to-date with their mandatory training. Mandatory training rates for medical staff were low with only 1 module, level 3 children's safeguarding meeting the trust target of 90%. Of the 11 modules 3 were 80 to 90%, and the other 7 were less than 80%. Although all were above 60%, fire safety, infection prevention and control and level 2 resuscitation were notably low.

For medical staff the BLS rate was 63%, the Advanced Live Support (ALS) was 63%, European Paediatric Life Support (EPLS) and European Paediatric Advanced Life Support (EPALS) 43%.

These latter courses were not mandated, and the trust ensured that they had enough qualified staff on each shift to provide the care needed.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training compliance was reported each month within the matron assurance report, and this highlighted those areas that needed attention which was managed through the associated action log.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all staff were updated with the relevant training.

Safeguarding training rates were recovering following problems accessing the courses during the pandemic. However, all this shortfall was being managed with staff being booked on to courses and monitored. In addition, all the shortfall was refresher training; all new starters were prioritised and so all staff had received training. This was confirmed by the new starters we spoke to, although one who had worked for 3 weeks had not had their booked training yet and was not able to talk confidently about how they would recognise abuse.

Staff were able to carry out their mandatory and other training on their days off if they wished and claim their time back.

One shortfall identified by managers in the safeguarding training provision was that while staff knew how to make referrals for female genital mutilation the training did not include how to identify it for staff trained to levels 1 and 2, although it was included in the level 3 training. This applied to child sexual exploitation too.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training rates for adults levels 1 and 2 were slightly below the trust target and for level 3 only 2 out of 6 eligible staff were current. For children's safeguarding levels 1 and 2 they were significantly above the trust target except for level 3 which was slightly below the target.

Medical staff received training specific for their role on how to recognise and report abuse. For medical staff the safeguarding children level 3 training was at 100% but the level 2 training was low at 74%. Safeguarding adults training was at 78%

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff gave us examples of safeguarding referrals they had made which included neglect in a patient from a care home, pressure sores that happened in the department, theft from a patient and welfare concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were posters for the Hospital Independent Domestic Violence Advice Service which was available to staff, as well as patients and relatives. We observed staff working with a local authority to discuss concerns they had about a family.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding referrals were done online and there were contact details online too. Staff knew how to refer and said that if urgent they would telephone local authority safeguarding teams for advice, something that we observed happening in practice.

Staff followed safe procedures for children visiting the ward. Staff in the children's area were confident and knowledgeable about safeguarding, the members of the safeguarding team and the named nurse for children's safeguarding. When we asked about recent safeguarding referrals, they referred to a family currently in the department with complex needs and how, as well as safeguarding they were referring parents into other agencies for help and support.

We also saw that when staff were concerned about a young person who attended with someone who caused concern, they discussed it immediately with the local authority's emergency duty team and steps were taken to make them safe.

Staff were aware of the Mental Health Act 2005 and the holding powers that doctors, and nurses had. Staff got advice from their mental health colleagues in the local NHS trust providing community mental health services as they needed it. Staff reported that the mental health team were very supportive and easy to access. There was a pathway to follow for paediatric patients who presented with mental health conditions together with a child orientated assessment.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. Although extremely busy and accommodating far more patients than for which it was designed the department was largely tidy and all areas were visibly clean. Similarly, toilet facilities, which were in high use, were of a satisfactory standard.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Audits of cleaning for the previous 3 months showed high rates of compliance which were always in excess of the trust targets.

Staff followed infection control principles including the use of Personal Protective Equipment (PPE). Hand hygiene audits for the previous 3 months demonstrated 100% compliance which was as we observed on inspection with staff adhering to required practice. Similarly, audits of the correct use of PPE, and compliance with uniform and bare below the elbow requirements were 100%. However, we did occasionally observe some poor wearing of disposable face masks in clinical areas with the mask worn below the nose or sometimes the mouth. All staff had been offered face fit testing and suitable respirators were available.

The hospital had suspended the use of "red" and "green" COVID-19 pathways in the emergency department (ED) as the infection and presentation rates no longer justified it. However, patients being admitted to respiratory or oncology areas were given rapid PCR swabs. Other patients about whom the staff had concerns were given LFD tests.

There was an infection prevention and control (IPC) link nurse who was working to deal with the risks associated with the increased use of the department. We were told, and saw through the action log of the matron assurance report, that this included increasing the number of hours cleaning provided by domestic staff as a result of increased complaints. However, the inspection team did not see any concerns about cleanliness.

Arrangements were in place to protect patients who were at particular risk from infection because of a compromised immune system, including those on cancer treatments. There was a sitting area identified in the unit where they could be kept away from other patients. However, this was also used for patients who were anxious about the crowded environment of the department.

We asked for audits of those procedures that were known to expose patients to the risk of infection, such as venous catheters, urinary catheters and taking blood for the previous 3 months. These showed greater than 96% compliance rates. Except for urinary catheter care for October 2022, which was at 75%. We also noted that these figures were reported through the matron assurance report so that all staff were aware.

Antimicrobial stewardship audits demonstrated good compliance with the required standards with 6 of the last 8 audits classed as “green” and 2 as “amber”.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Barcodes were being introduced to enable the cleaning of trolleys to be managed and audited.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe but the department could not accommodate the number of patients using the service. However, there was enough equipment and staff were trained to use it. Staff managed clinical waste well.

The hospital was building a new ED on the hospital site and this was expected to open in April 2023. We inspected this aspect of the service with this in mind and the requirements made on the provider reflect that.

The design of the environment mostly followed national guidance including that recently issued to accommodate patients in corridor areas to allow ambulances to unload.

Patients were held on ambulances in the parking bay and roadway outside of the department close to the ambulance entrance. Hospital staff working outside in the ambulance bay were provided with warm clothing, radios and suitable PPE including high visibility jackets.

The reception area was sometimes overcrowded with people standing. The chairs, being made of metal, were unsuitable for the time people were having to spend seated. The staff were aware of this, provided cushions, and directed vulnerable people to the limited numbers of soft, high backed chairs. Senior staff told us patients were often sitting when they should be in a bed.

Ambulance staff took patients brought in by ambulance, through to a separate area from those patients who arrived themselves. There was a 4 bedded resuscitation area which included 1 bay specifically equipped for children, as well as adults. We noted that this area was small for the number of bedspaces.

There were 4 majors cubicles, plus 4 beds in a “high care” area which largely accommodated patients with respiratory illnesses.

There was a children’s area separated from the adult’s area. It had secure door controls and we saw that access was monitored and controlled. The children’s area was suitably decorated and equipped including toys. There was a separate area for older children.

Because of the high demand and difficulties in achieving flow within the department temporary patient accommodation had been introduced. The increased staffing to care for additional patients had also resulted in the need for more seating for staff to carry out their work and additional seating had been added. However, this added to the crowding of the environment and the work areas were not always suitable.

Urgent and emergency services

Patients were accommodated in the corridor next to the ambulance area and there were 2 rapid assessment and treatment cubicles into which patients were moved for examination and treatment. This area was assessed as suitable for 10 patients although 12 could be accommodated if necessary. An additional 3 patients could be accommodated in the corridor next to the intensive care unit. This required a fire door to be wedged open and there was a sign on the door saying that the door was to be kept open and that this had been risk assessed. There were also fire safety instructions displayed that indicated the 2 escape routes that were to be used dependent on the location of any fire.

Managers had recognised that the crowding of the department introduced additional risks from fire and challenges should any evacuation be needed. It was identified as a risk on the departmental risk register. We saw risk assessment records that identified the specific risks from fire and crowding and implemented mitigations and control measures including the method of evacuation. The provider was aware of recent bulletin from NHS England about the fire risks when increasing capacity in clinical areas. Our inspection coincided with a scheduled inspection by the Fire and Rescue Service. They visited the ED as part of their visit and found no concerns.

However, during the inspection, we found 2 doorways which were signed as fire exits partly blocked by chairs or trolleys. We drew this to the attention of staff, and it was quickly dealt with, but this was an issue possibly resulting from the crowding of the department.

There was also an “overflow area” with 9 beds for patients waiting for admission. This was mainly used to provide a comfortable and safe area for frail patients and was supervised by the geriatric emergency medicine team led by a nurse practitioner.

There was a dedicated and specially designed mental health assessment room with observation facilities and no blind spots. However, there was a broken coffee table in the room that could have been used to cause harm. It was not clear how or when it had been damaged but we drew it to the attention of staff who dealt with it.

There was no separate provision for patients suspected of having COVID-19 to be separately streamed, which reflected national guidance.

There was a dedicated decontamination area adjacent to the ambulance entrance that was being used for storage. We were told that it was out of use and that there was a specialised portable shelter that would be used for decontamination purposes. The keys for this area were accessible. While there was a facility that could be quickly setup for multiple casualties, there was no working dedicated area that could be used in an emergency to decontaminate a patient.

The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment. We checked 3 resuscitation trolleys located in the resuscitation, majors and children’s areas. All were secure with tags to show they had not been opened since they were last checked by staff. Paperwork showed that a full trolley and suction test took place each month, the tags were checked each day and the trolleys restocked when used.

We checked the equipment suction and defibrillation equipment on the top of each trolley, but we did not break the seals to check the contents as this would have meant the very busy staff would have had to recheck and reseal the contents themselves.

There were additional pressure area mattresses in the department and access to more through a library.

There were no piped air outlets in the department, all air provision was through cylinders. This was in line with recent national patient safety alerts and ensured that the risk of a patient needing oxygen being connected to an air outlet was eliminated. We noted from notes of departmental meetings that this had been discussed and the risks associated with the provision of nitrous oxide also considered.

Oxygen cylinders were kept in a dedicated storage room and there were clear instructions to segregate empty cylinders from those in use.

Most patients could reach call bells and staff responded quickly when called. Some patients told us call bells were not available due to them not being in a proper bed, but one said they realised that they were in clear view of staff and could attract their attention. As well as call bells, in the cubicles there was signage advising carers that the red alarm button could be used to summon urgent help.

The service had suitable facilities to meet the needs of patients' families. There was a relatives' room that afforded privacy and allowed confidential conversations. It was pleasantly furnished and despite the space difficulties in the department it was kept reserved for its intended use.

Staff disposed of clinical waste safely. Sharps bins were in use and we did not note any that were overfull nor staff disposing of sharps inappropriately.

Assessing and responding to patient risk

There were delays in moving patients off ambulances into the ED and in triage when the department was full. This resulted in delays in assessment and treatment for some patients. However, staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff usually identified and quickly acted upon patients at risk of deterioration.

Overall, we found that, despite the considerable pressure, there were significantly improved processes to assess, monitor and treat patients compared to our last inspection. However, the department was under considerable pressure and assessments and particularly reassessments were not always completed as required.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Patients attending on foot were usually triaged within the 15-minute target.

Patients who could not immediately be brought into the department were triaged on the ambulance using the provider's Global Risk Assessment Tool (GRAT). This was meant to be done within 30 minutes and to be reassessed every 60 minutes, but we were told that this was not always met but this was mitigated as the patients on ambulances were in the close care of medical professionals. There was an escalation procedure in place in the event that the requirements were not being met and the GRAT performance was audited.

For patients who were in the department this GRAT process was triggered after 6 hours and they were reassessed every 2 hours from then onwards. In addition to the nurse assigned to the GRAT role there was a GRAT consultant identified between midday and 10pm who provided medical support.

There was a system to identify people who had waited longer than 6 hours in the reception area. This triggered an assessment including a nursing pack, and when indicated the provision of cushions for the hard seats.

We were told by several staff of the concerns about sick patients in reception and minors and that their acuity could not be inferred from how they arrived at the department. As a result, the GRAT was soon to be piloted in these areas. This meant that patients both in those areas and in the ambulances would be considered in the same pool and receive similar triage and observation.

Safety huddles took place in which staff could raise issues and the overall safety of the department and individual patients was reviewed. Four were scheduled throughout the day but additional huddles could be arranged by staff at any time.

We observed the safety huddles taking place and noted that they were well run. Capacity and flow issues were escalated to the site team but there was not always a solution.

As an example, we saw a safety huddle take place when the 4 bedded resuscitation unit had 3 patients and the ambulance service pre alerted that 2 sick patients were on their way. There was a good conversation as to how to deal with this with options, such as accommodating 5 patients in the resus bay and if not, which patient was lowest risk to move out. In another case there were 4 patients in resuscitation, 4 in majors and a pre-alerted patient on their way. Again, this was handled well but indicated how busy the department was and senior staff were constantly having to manage capacity and flow.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used the National Early Warning Score (NEWS) and this was integrated into the GRAT system.

We selected and looked at the records for 7 patients who were in the department. Despite staff telling us that triage was a challenge all had been seen within 15 minutes and had been seen by a doctor within a reasonable timescale considering their presentation and the challenges faced by the department. Most of the patients were being appropriately monitored with their risk scores correctly calculated. However, a patient who had been identified as suspected sepsis, who had been seen by doctor and prescribed antibiotics to be given in the next hour had not yet received their medication after 3 hours. We had to draw this to the attention of senior staff who immediately addressed the issue.

Within the department the staff relied on electronic record systems including their electronic patient record (EPR) system which was able to be modified to adopt new working practices. This meant that the recent GRAT forms were available electronically alongside NEWS. We saw that this information was well presented and being used frequently by staff, including in safety huddles, to understand both individual patient's condition and the overall risk in the department.

We were provided with the NEWS audit results for the previous 3 months. These showed that the rate of patients being assessed was very high at 100, 96 and 99%, and the rate of the NEWS being calculated correctly was 97, 90 and 95%. These latter scores were just below the trust's target threshold. Where any shortfall was noted the patient was reviewed to judge whether harm had occurred and for the 4 patients that this involved during the past 3 months, there was an explanation, such as the patient was undergoing resuscitation and no harm had occurred.

Sepsis treatment and recognition was audited in the ED. Results for the 3 months prior to our inspection showed that for July and August 2022, the percentage of patients screened was 100% but for September it dropped to 78%. This gave an overall compliance of 91%, which was above the trust's target. For those patients identified as a concern, 76% had completed the Sepsis Six pathway within an hour, which was below target and 86% had received their antibiotics within an hour which was above the target.

Urgent and emergency services

Staff knew about and dealt with any specific risk issues. When we looked at our sample of patient records the appropriate assessments had been completed for the patients, including falls and venous thromboembolism (VTE).

Staff told us that because of the length of time some patients were spending in the department, often on unsuitable seats and ambulance trolleys, that the risk of patients developing pressure ulcers was of concern. For the patients on trolleys and in beds skin checks formed part of the hourly checklists. After 6 hours on a trolley, patients were transferred to a bed, or sooner if indicated.

When we looked at incidents, we saw that pressure area injuries were reported both when they had occurred outside of and within the department. It was also the case that falls were reported. Management meeting minutes noted that the number of patient falls had dropped during August and September 2022, having been a concern over the previous months.

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. When we asked for figures for the response of these services, we saw that for 50% of the referrals they responded within 30 minutes and the average time was 48 minutes.

During our inspection we saw a patient who was distressed by the unfamiliar environment and was acting aggressively to staff and patients in the corridor area. We noted that the situation was handled well with the lowest possible level of restraint while keeping people safe. We also saw that this was another example of hospital and ambulance staff working well together with the crews providing valued support. When we saw the patient later in our inspection, they were under constant observation but calm and no longer distressed.

Staff shared key information to keep patients safe when handing over their care to others. There was a protocol for ambulance crew to handover their patient to the hospital including how to escalate concerns. Reminders of this were displayed in the ambulance entrance to the ED.

Shift changes and handovers included all necessary key information to keep patients safe. There were handover meetings at each shift change

Patients who chose to leave the department before assessment or treatment were assessed against a checklist and given suitable advice as to any risks that they were taking. Posters throughout the department advised patients who wished to leave to speak to a member of staff before doing so.

Staff who had worked in the department for some time told us that it was much safer than at the time of our previous inspection, and that while the department could look disordered it was actually under control.

Staff liaised with the trust's acute oncology service (AOS) in respect of those patients attending the department who were undergoing cancer treatment. During the working day a liaison nurse from this service was available to assess and if necessary, admit the patient to the AOS.

Urgent and emergency services

Staffing

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe, but the service had high vacancy rates. The department was funded to have an adequate number of staff, but vacancy rates were currently at around 20%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The number of nurses and healthcare assistants matched the planned numbers. On the second day of inspection, we assessed the staffing levels and the nursing rotas were fully staffed for the day and evening shifts. Figures for the previous 3 months showed that the average fill rate for core qualified nursing staff on both day and night shifts was in excess of 97%. For emergency nurse practitioners, it was consistently around 75% but these represented less than one sixth of the staff on duty and were not rostered on nights.

The children's department usually had 2 trained children's nurses in line with the recommendations of the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings'. On some occasions when this was not possible, due to sickness, an adult nurse with paediatric competencies would be assigned to support them. There was always at least 1 trained children's nurse supported by an adult nurse with suitable paediatric competencies. Figures for the last 3 months showed that this happened on around a quarter of shifts but, as staff had told us, the average fill rate for the children's department on both days and nights was in excess of 95%.

However, while nurses told us that that the children's department was always safe because they operated independently of the adults' service and transferred their own patients, they often were unable to take breaks. We also saw, through the notes of the senior departmental meeting that additional nursing time had been requested as they sometimes struggled to carry out repeat observations when the department was busy.

There were 2 nurses and 2 healthcare assistants assigned to look after patients in the corridor. When we observed this area, we noted that although it was very busy the staff were managing, and patients were not left in distress.

The service had slightly high turnover rates. Turnover rates were stable at around 16% which was slightly higher than the national rate.

The service had low and/or reducing sickness rates. Managers told us "sickness is a challenge" but sickness rates for nursing staff were stable and typical for the type of service at around 5% over the last 6 months.

The service had high rates of bank and agency nurses. Managers were not able to limit their use of bank and agency staff but did request staff familiar with the service. There was high use of bank and agency staff amongst adult nurses with daily figures around 35%. For children's nurses the rate was more variable because of the smaller numbers of staff but there was an upward trend over the past year with current rates around 25%.

Managers made sure all bank and agency staff had a full induction and understood the service. Although agency staff were used a lot, particularly on nightshifts, they were drawn from a consistent pool of people who were familiar with the department.

Urgent and emergency services

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. The service had a good skill mix of medical staff on each shift and reviewed this regularly and this was in line with the Royal College of Emergency Medicine (RCEM) recommendations.

The service had high vacancy rates for medical staff. The vacancy rates for trainee grade doctors was high at 38% for the last month, a figure that had been increasing. However, for staff grade doctors and consultants it was 7% and 10% respectively and there had been an increase in consultant numbers over the previous 12 months.

The service had typical turnover rates for medical staff. Turnover rates for the second quartile of 2022 were around 6% rising to 11% for the third quartile.

Sickness rates for medical staff were low. Sickness rates for medical staff were stable and low at around 2% over the last 6 months.

The service had high rates of bank and locum staff, but managers could access these locums when needed. There were high rates of locum usage primarily in the foundation year 2 (FY2) and specialist trainee level 3 (ST3) grades but this meant that shifts were covered against the vacancies at those grades. There was also use of consultant locums noted, again ensuring those senior roles were always covered. Managers made sure locums had a full induction to the service before they started work.

Staff in the children's department told us that they got good medical support from within the department and consultant staff from the Paediatric Assessment Unit would "always come down". Children's nurses said they would be asked to attend the resuscitation area if needed and that they were confident in the doctors there as all the ED consultants had paediatric competencies. There was an identified paediatric lead consultant for the department.

Records

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

Patient notes were comprehensive and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. Within the department the staff relied on electronic record systems including their EPR system which was able to be modified to adopt new working practices. This meant that the recently introduced GRAT forms were available electronically alongside NEWS. We noted that the presentation of notes and key information, such as sepsis and NEWS was very clear on this system and it was in constant use for the management of individual patients and the department as a whole.

Overall record keeping both written and electronically was considered to be done well by the inspection team. The department carried out reviews of patient's notes as part of their weekly nursing quality checks and these demonstrated that the notes were almost always completed to the required standard.

Urgent and emergency services

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, staff did not always store medicines safely.

Staff followed systems and processes when safely prescribing, administering and recording medicines. A team of prescribing pharmacists and pharmacy technicians worked within the ED 7 days a week. They were an established and integral part of the team ensuring that systems and processes were followed when safely prescribing medicines. They solved patients medicine problems, prevented clinical deterioration by ensuring the prescribing of time critical medicines was undertaken and patients received their medicines.

There was always at least 1 prescribing clinical pharmacist in ED. The clinical pharmacist spoken with was a frailty practitioner and worked collaboratively with the geriatric emergency medicine team to ensure safe prescribing of medicines.

Prescribing of medicines including antibiotics and length of treatments were documented in patients notes and on medicine charts.

Medicines supply from pharmacy was available and staff knew the routes to obtain medicines out of hours if required.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team within ED reviewed patients' medicines on admission and gave medicine advice and prescribing support to all the ED team. The pharmacy team also provided counselling to patients and carers. The department made use of an "Optimisation of End of Life Care" protocol which gave good guidance on suitable anticipatory medicines and we saw this being used for some patients. ED staff could also access the trust's palliative care team for support.

Staff completed medicines records accurately and kept them up to date. Documentation of medicines administration including routes of administration and specific times of administration were completed on all medicine records reviewed.

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.

Weights of patients were recorded on medicine administration records which is important for calculating the dose of weight-based medicines.

VTE risk assessment outcomes and prescribing were completed on all patients notes reviewed at admission.

Staff stored medicines securely but did not always store them safely. Medicines were stored in dedicated secure storage areas. An automated electronic medicines storage system in majors ensured medicines were available, safe and secure with restricted access to authorised staff. However, it was difficult to easily access medicines from the storage system in minors. It was in a busy patient corridor and a filing cabinet had been placed directly opposite the storage which meant when the door was open nobody could walk along the corridor. This made it difficult for staff to access medicines safely. We saw that senior staff were aware of this issue and it was discussed at the departmental meetings.

Medicines were not always stored safely. For example, in resus, we found loose strips of medicines in the medicine cupboard door. This increased the potential risk of a medicine error or a medicine not being located. Also, in the minors

clean utility room there was a tray left out on the workbench containing medicines. It contained various boxes of medicines some of which were labelled for named patients who were no longer in minors, loose tablets and loose ampoules. We spoke with 4 members of staff who were not aware of these medicines. The medicines had not been stored safely or removed for destruction.

Emergency medicines and equipment were available and expiry dates checked were in date. They had 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 (CDs) (CDs are 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. However, it took some time for the CD keys to be located and returned to the nurse in charge. We were therefore, not assured, that CDs could be accessed immediately if they were needed for a patient.

Medicines requiring refrigeration would normally be stored in 3 fridges, however, 2 medicine fridges were not in use. This meant all medicines requiring refrigeration were stored in 1 fridge which was in a patient bay within resus. We were unable to access the medicine fridge due to the presence of a patient who was very unwell. This raises potential issues of easy access to medicines as well as not protecting the privacy and dignity of patients.

Prescription pads were stored securely with records which is seen as good and safe practice.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The clinical pharmacy service within ED undertook prescribing of medicines, medicine history reviews, medicine reconciliation and clinical checks on prescribing. This ensured patient's medicine records were up to date and accurate before they were admitted or moved between services.

Staff learned from safety alerts and incidents to improve practice. The trust had an electronic system for recording incidents and staff we spoke to were able to explain its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported. When we reviewed incidents, we saw that drug errors, missing drugs and other issues were reported.

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 investigated incidents thoroughly. Managers debriefed and supported staff after any serious incident. We looked at all reported incidents for the previous month and it was clear that there was a culture of reporting concerns in the department. All incident reports were seen by all consultants and each took a lead role for different types of incident.

Incidents, together with an analysis of themes and performance on investigation were included as part of the monthly matron assurance report.

Urgent and emergency services

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy. Staff to whom we spoke said they knew how to report incidents and were able to give recent examples. This included a new starter who told us that they had reported their first incident the previous week.

The service had had no never events during 2022.

Staff understood the duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they were given feedback about incidents that they reported and that reports were taken seriously.

Staff met to discuss the feedback and look at improvements to patient care. This was evidenced through the notes of staff and management meetings. There was evidence that changes had been made as a result of feedback. In one example we were given, following the collapse of a patient in the reception area, and difficulty in carrying out resuscitation in the cramped environment, a trolley and wheelchair had been placed in the area, so a patient could be quickly transferred to the main department.

They also incorporated the trust's safety quality information dashboard (SQuID) which reported on any harm caused by untoward incidents as well as key audit results.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Suitable clinical pathways were in use and adhered to. We observed that a walk-in patient was quickly identified as being sick and taken to the resuscitation area. There was good adherence to the appropriate pathway for this patient, they had their condition assessed and consultant review on time as well as their National Early Warning Score (NEWS) updated.

We noted many other clinical pathways in use, including those for sepsis, and that these were detailed and suitable. They were also often wall mounted in sturdy wipe clean books for ease of reference. The pathways frequently incorporated templates which enabled structured care to be more easily given against the pathway by locum staff who were not familiar with the department.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff, to whom we spoke, were familiar with the act and the holding powers of doctors, and nurses.

Urgent and emergency services

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Because patients spent much longer in the department than the emergency department (ED) was designed for, the trust had responded by providing hot and cold drinks, sandwiches and snacks free of charge to patients and their relatives. These were located around the department including the walk-in area and people could help themselves without having to ask. Patients who stayed in the department for a long time also had hot food provided. Food and drinks rounds took place by staff and volunteers. Food and drink in the children's area was suitable for their needs. There were food options available to meet patients' religious, cultural and dietary needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Our review of patient notes showed that these assessments and documentation of fluid balance took place when appropriate.

Pain relief

Staff usually assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The pain tool used by the department scored pain on a scale from 1 to 10 but also enabled patients to describe the type of pain. The Abbey Pain Scale was in use for patients who could not vocalise.

Patients received pain relief soon after it was identified they needed it or they requested it. Staff prescribed, administered and recorded pain relief accurately. When we looked at our sample of patient records, we saw that patient's pain had been assessed and relief given when needed. This was corroborated by what patients told us and they also said that staff reassessed and provided more medication during their long stay. Audit of the nursing care and comfort rounds, which included pain assessment in the package showed that the trust targets were consistently met.

Pain relief for fractured neck of femur had been audited and drawn the conclusion that the department was "significantly underperforming" for pain management in these patients. The lack of space and patients being held on ambulances were suggested as contributing factors. We noted that this represented a small number of patients as these patients should be treated at the trust's other ED in Redditch. We also saw notes that indicated that there was an action plan in place to improve the department's performance.

Staff told us they were proud that the recent Royal College of Emergency Medicine (RCEM) audit for pain in the children's department gave a good score and children in moderate pain always received pain relief within 20 minutes. We could not fully corroborate this as the trust was awaiting the validated report, but we saw that the score for pain assessment on arrival was 95% against a national average of 62% and children with moderate or severe pain always had their pain reassessed as required.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. They completed RCEM audits on an annual basis. 'Pain in Children', 'Infection Prevention and Control' and 'Consultant Sign Off' data had just been collected; therefore, the results and analysis were not fully available.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The department participated in a 'Better Outcomes for Patients Programme' (BOPP). This was a series of audits which are chosen by the directorate to look at specific aspects of care within the department. Examples we saw included, "Mental Health Matrix"', "Abdominal Aortic Aneurysm" and "Procedural Sedation". There was a BOPP workshop planned for December 2022. The purpose of this workshop was for all divisions to set their BOPP audits for 2023/24 using the current data and feedback from incidents and complaints where change for quality improvement was required.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care, treatment and patient's outcomes. Antimicrobial stewardship audits took place each month although 3 were missed in the winter of 2021/22 during COVID-19 and winter pressures. National RCEM audits took place as required and 5 local audits had taken place against RCEM guidance.

The service had a lower than expected risk of re-attendance than the England average. Consistently, nearly 6 to 7% of patients who attended the ED over the previous 6 months reattended within 7 days which was lower than the current national average of 8 to 9%.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and usually held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Medical and nursing staff, including those from agencies, were suitably qualified and experienced in emergency medicine and the department's rosters ensured there was a safe skill mix.

Medical consultants were all on the General Medical Council's Accident and Emergency Medicine Specialist Register and unlike our previous inspection trainees were not identified as consultants on the rotas.

The children's department usually had 2 trained children's nurses in line with the recommendations of the 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings'. On some occasions when this was not possible due to sickness, there was always 1 trained children's nurse supported by an adult nurse who had suitable paediatric competencies.

Staff in the children's department told us that they got good medical support from within the department and consultant staff from the paediatric assessment unit would "always come down". Children's nurses said they would be asked to attend the resuscitation area if needed and that they were confident in the doctors there as all the ED consultants were required to be competent in the management of children.

Managers gave all new staff a full induction tailored to their role before they started work. New starters confirmed to us that they had had an induction period when they joined the department. One of these was a nurse from overseas who had an "International Nurse Link Worker" to support them with integration both in and out of work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that they received supervision and new starters said they got additional support. However, senior staff told us that it was difficult to find time to do this because they needed to support the very busy department. Some senior staff said this resulted in them working excessive hours.

Compliance with Personal Development Reviews (PDR) and clinical supervision was reported each month within the matron assurance report, and this highlighted those individual staff who needed a PDR. For example, we saw that the compliance for September 2022 was 88% against a target of 90%, and there was an action for staff to ensure they booked a review if they needed a review.

We saw that the PDRs numbers being below the trust target was discussed in the relevant management meetings.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw, through the notes of meetings that these took place, were documented and made available.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs, including specialist training, with their line manager and were supported to develop their skills and knowledge. Staff discussed their training needs through the PDR system and there were many staff who had progressed through the department.

Managers recruited, trained and supported volunteers to support patients in the service.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The trust held regular meetings with partners in the local health economy to discuss patient flow and access to other services.

Staff worked across health care disciplines and with other agencies when required to care for patients. The ambulance service provided a hospital ambulance liaison officer between 10am and 10pm each day. We observed a good working relationship between them and the hospital staff although it was clear that those staff members were under a great deal of stress as was a duty manager. This good working relationship extended to all the crews and hospital staff we saw working together.

However, there was some dissatisfaction expressed about the time it took to get assessments of patients by other specialities in the hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff got the advice from their mental health colleagues in the local NHS trust providing community mental health services as required. Staff reported that this service was very supportive and easy to access. There was a pathway to follow for paediatric patients who presented with mental health conditions together with child orientated assessment.

Seven day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. Computerised tomography (CT) scanning and plain film X-ray was available 24 hours a day, 7 days a week. Staff told us there was no problem obtaining blood results and there were enough blood gas analysers in adjacent areas to cope with unserviceability. Magnetic resonance imaging (MRI) was not a 24-hour service.

There was a cardiac catheterisation suite available 24 hours a day, 7 days a week with a 40 minute on-call response out of hours. Thrombolysis for stroke patients was done on site but patients needing thrombectomy would be transferred to a specialist regional centre.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. There were information leaflets in patient areas, and these addressed appropriate topics including cancer, mental health, nutrition, alcohol abuse and how to access services other than the ED.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. We looked at the records of 5 patients and we considered that consent was obtained and documented correctly. Two of these patients were children and 1 was an adult with learning disabilities. In all these cases consent was obtained in conjunction with the patient, parent and or carer within the relevant legislation.

We identified 2 patients who had Do not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions in place. For both, the documentation, the decision and reasoning were recorded as being taken by a named doctor with the patient and, or relative's involvement. One patient had a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in place, and this had been consulted as part of the decision making.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were given mandatory mental capacity and depravation of liberty training and were able to give examples of how mental capacity assessments were carried out. We looked at the notes for a relevant person in the department and saw that capacity assessments had been carried out and best interest decisions were being made in consultation with their carers.

Urgent and emergency services

Is the service caring?

Good ↑

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

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. However, the significant numbers of patients treated in corridors meant staff could not protect their privacy and dignity.

Within the constraints of the overcrowded department, staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Many patient's privacy and dignity was compromised as they were being nursed in open corridors in full view of staff, other patients and their relatives. However, we did note that they were afforded privacy through blankets and we did not see patients in a state of undress as had been the case in our last inspection. Patients were usually taken to cubicles for examination, treatment and confidential discussions. We did see some conversations between staff and patients taking place in places where they could be overheard.

One patient complained that they had to discuss a sensitive matter in a public area because there was nowhere private to go. Another patient complained that they were not able to get to a toilet and a third told us they were upset about all the delays and wanted to go home. A member of staff told us that there was a great deal of stress among patients and this was reflected in their behaviours, including violent incidents.

Patients said staff treated them well and with kindness. We saw that staff were kind and compassionate in their interactions with patients despite the considerable stress they were under. Most patients we spoke to, and examples of feedback we saw, were complimentary about the staff, some exceptionally so, although they were often unhappy with the conditions and the delays in the department. However, we also saw complaints posters in staff areas saying that "values and behaviours" was a theme of complaints and how to change this.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patients who visited the department were sent a text on their mobile phone following their visit with a survey. The trust's urgent and emergency care Friends and Family Test performance for September 2022 was 84%, which was below the target. There was a 20.2% response rate which was above the trust target.

Throughout our visit the front door to reception was staffed by security personnel from a private company. We saw several situations where they dealt with angry patients or people inappropriately trying to access the department and these were deescalated without incident. They were also proactive in assisting people who arrived and departed by car or taxi and their caring approach to their work was noted by several members of the inspection team.

Staff followed policy to keep patient care and treatment confidential. Records were kept secure and computer displays were positioned so only staff could see them.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. This was an aspect of care we observed when staff interacted with patients and discussed them amongst the team.

Urgent and emergency services

Emotional Support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. There was a relatives' room that afforded privacy and allowed confidential conversations. It was pleasantly furnished and despite the difficulties with space in the department it was kept reserved for its intended use.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We observed care being given to distressed patients and the staff moved them to more private areas if possible. The department had identified that some patients became anxious due to the overcrowding or their existing condition. There was a quiet, access-controlled corridor area that was used for them if they were "fit to sit".

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The feedback from the Emergency Department Survey Test was positive. The urgent and emergency care survey 2020 report showed that the trust scored better than other trusts for being listened to; the patients felt the health professional listened to what they had to say.

Staff talked to patients in a way they could understand, using communication aids where necessary. We saw that there were resources available, for example pain scores, to allow staff to communicate with patients who had difficulties.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The emergency department scored above the trust's target for getting patients to feedback through the Friends and Family Test.

Staff supported patients to make advanced decisions about their care. The department made use of an "Optimisation of End of Life Care" protocol which required communication with the patient and relatives, and we saw this being used for some patients.

Staff supported patients to make informed decisions about their care. Patients were given a letter on arrival at the hospital that explained why they might be cared for in a corridor or as a "boarded" patient on a ward. There were explanatory posters throughout the department explaining about how the assessment, triage and prioritisation systems were currently working.

Is the service responsive?

Requires Improvement ↑

Urgent and emergency services

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service did not provide care in a way that met the needs of local people and the communities served. However, it was working with others in the wider system and local organisations to better plan care.

The overall service did not meet the needs of the local population. Over the long-term patient numbers had increased, and the service did not meet demand. Patients were waiting for long periods of time to be seen in the department and to be moved out of the emergency department (ED) into a hospital ward. Leaders analysed capacity and demand daily. However, despite the increased demand, patients we saw were usually safe and well cared for.

The senior leadership team met on a monthly basis and discussed the pathways within the department and made improvements where required.

Facilities and premises were not appropriate for the services being delivered. The department could not always accommodate the number of patients in the department. Patients were waiting for long periods of time to be seen in the department and to be moved out of the department into a hospital ward.

There were not enough beds in majors which meant that patients were cared for in the corridors on trolleys. Patients spent long periods of times on trolleys or on ambulances outside of the department. Staff did move patients onto beds if they were in the department for an increased amount of time.

In the children's department there was a separate and suitable waiting area for adolescents which benefited all children.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. There was a dedicated and specially designed Mental Health Assessment room with observation facilities and no blind spots. There were pathways in place to access mental health support for both adults and children and staff told us the service was responsive and supportive.

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. The department had allocated a bedded area separate from the rest of the department where patients who were frail, or living with dementia, could be cared for in a calmer and less crowded environment.

We saw patients with dementia being distracted by staff by sitting them close to the nursing station and interacting with them. However, we also saw patients with dementia on trolleys and their relatives struggling to keep them calm and out of distress.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The service had information leaflets available in languages spoken by the patients and local community. There were many leaflets available but only in English. When we asked staff, they said that there were few people who did not speak English and when they did not the languages spoken were uncommon.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The department had access to online interpreters through a contract with a commercial service. Any member of staff could use it by calling and entering a PIN code and there were charts to identify some 60 languages. There was also the facility to book a British Sign Language (BSL) interpreter through another provider and this organisation offered an emergency service.

There was information to help staff communicate with patients who were deaf outside of the use of sign language and there was additional provision for BSL through a list of willing staff organised through a social media platform by the chaplaincy.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The food provided in the children's department was different to that of the adults and suited to their needs.

Staff had access to communication aids to help patients become partners in their care and treatment. There were some pictorial guides so that people with hearing, learning or speaking difficulties could communicate their basic needs, such as needing pain relief or the toilet.

Access and flow

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

Managers monitored waiting times but were unable to make sure patients could access emergency services when needed and receive their treatment within agreed timeframes and national targets. When we visited at 9pm on the Monday night of our inspection, we noted that of the 15 ambulances parked outside 14 of them had patients on board who could not be admitted into the department. However, children were never held on ambulances and always brought into the department.

We saw information that 57% of the complaints received by the trust were in respect of the ED at Worcestershire Royal Hospital and of these 79% were about delays.

During our inspection the safety matrix status of the department was categorised as "Overwhelmed" with the rest of the hospital at level 3, "Severe Pressure". All senior staff identified flow through the department as the most significant challenge. Many staff told us, and we saw ourselves, that the department was overcrowded, and patients experienced long waits which resulted in undignified care and additional clinical risk.

Staff in the children's department told us that while the department was very busy with demand, because children were discharged to the care of their parents they were not affected by any lack of community or social care beds. This meant they rarely struggled to admit patients into the hospital from the children's ED.

The department consistently failed to meet the 4-hour wating target, often by a significant margin with rates of below 60% being common. In November 2022, 966 patients waited more than 4 hours with a mean waiting time of 8 hours. Twelve-hour breaches were also common and although on some days there had been no-one waiting 12 hours, on other days we saw figures of 25 patients. On each day in November 2022 there was an average of 10 patients waiting more than 12 hours. We saw data that some patients had waited in the department for more than 60 hours.

Urgent and emergency services

Every member of staff we asked, including managers and ambulance crews were clear that once an ambulance stopped outside of the department the patient was the responsibility of the ED and this was not an issue of contention between the hospital and the ambulance service.

The ambulance service provided a hospital ambulance liaison officer between 10am and 10pm each day. We observed a good working relationship between them and the hospital staff although it was clear that ambulance crew were under a great deal of stress as were their managers who we spoke to during our visit. This good working relationship extended to all the crews and hospital staff we saw working together.

Although they were assessed, patients were not treated on ambulances, nor were tests carried out. This was because there were not enough hospital staff to safely supervise them while on the vehicles. The possibility of supervision by paramedics had been explored with the ambulance service but it would be outside of their scope of practice and appropriate training could not be provided.

The department was overcrowded, and this impeded flow within the department as it was often unclear why a patient was in a particular area. The department had introduced a role called a “progress chaser” who ensured tasks were followed up on and released clinical staff for patient care. The vacancies were currently out to advert.

We observed the safety huddles taking place and we noted that they were well run. Capacity and flow issues were escalated to the site team.

Meetings to address flow, discharge and admission from the ED took place throughout the day. This was in line with the organisation’s Full Capacity Management Policy. At the time of our inspection the hospital was on escalation level 3, “Severe Pressure” and the ED itself was at a safety matrix status of “Overwhelmed” and there were 4 capacity/site meetings, and 2 discharge call meetings with Integrated Care System partners. There was also provision for health economy teleconferences to take place at weekends and on bank holidays.

We attended site/capacity meetings and 1 discharge call meeting during our inspection. These meetings were well run and discussed relevant issues, such as demand, capacity within the hospital and to discharge, as well as the level and safety of staffing. However, it was notable that such were the pressures on the hospital very senior staff were discussing details and making decisions down to the level of individual patients.

These meetings were documented with regular “sitrep” reports going to the executive team as well as others. There was a clear process in place with data and decisions being documented. However, we were told that the situation was such that the processes were being reviewed to incorporate changes that were being implemented and “sign off” was expected in December 2022.

When we asked staff how proactive other hospital departments were at “pulling” patients from the ED they told us there was variability and identified some departments positively and commented on perceived problems with others. We requested and saw figures that demonstrated this variability although this data sometimes contradicted what we had been told.

The capacity problems extended to specialist wards, such as the Intensive Therapy Unit and a lead consultant told us patients who needed a bed there were staying in the ED far longer than they should. We were also told of a patient who went for interventional radiology who was returned to the ED rather than a suitable ward as no beds were available and patients in the hospital’s discharge lounge becoming so unwell while waiting to go home that they came back to the ED.

Urgent and emergency services

The hospital had recently implemented a “continuous flow model”. This “pushed” patients from the ED into wards where they were obliged to accommodate the patient through means, such as discharge or accommodating patients on seating or beds located in spare areas, a process known as “boarding”.

As the hospital was on level 3 escalation, there was a command meeting that took place mid-afternoon at which senior staff including the chief executive were present.

We saw decisions to provide additional support to the ED, for example in providing foundation year doctor cover for the ED to support the clerking of patients.

Managers and staff started planning each patient’s discharge as early as possible, but they often had limited options as the discharge pathways to community hospitals, care homes or to their own homes with domiciliary care support often had no capacity to accept patients.

Managers and staff worked to make sure patients did not stay longer than they needed to but patients often stayed much longer in the department due to capacity and flow. When we discussed the ED metrics with senior medical staff, we saw poor performance figures linked to the overcrowding. It was also clear that there was no significant increase in the caseload, in terms of numbers and acuity presenting to the ED, meaning the overcrowding was resulting from the inability to get patients out of the department.

In the walk-in area we observed many patients complaining to one another about the waiting times and comparing their experiences. When we spoke to patients, while frustrated, they were mostly understanding of the circumstances.

The number of patients leaving the service before being seen for treatments was comparable to national averages at 7 to 8%. Patients who chose to leave the department before assessment or treatment were assessed against a checklist and given suitable advice as to any risks that they were taking. Posters throughout the department advised patients who wished to leave to speak to a member of staff before doing so.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. The department worked with the discharge coordinators across the rest of the trust. We noted particular frustration amongst the ED team in their inability to get 2 patients in mental health crisis into suitable accommodation outside of the hospital. We observed senior ED staff spent some time trying to arrange with the local mental health trust admission to a safe area.

Staff supported patients when they were referred or transferred between services. Because the department was so busy patients were often transferred to wards by staff from those wards but those handovers of care that we saw were safe.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. There were information boards around the department telling patients how they could make a complaint and also how to get support from the Patient Advice and Liaison Service.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. We saw through the notes of management meetings that there had been a steady increase in complaints and although the response rate had been a concern with only 59% being replied to within 25 days during August 2022, this had recovered to 75% as reported in the October 2022 governance figures.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw posters informing staff of the most common complaints themes as well as specific complaints and how the department was responding. The most common themes were communication, rudeness, cleanliness and above all overcrowding and delays.

We also saw that the trust celebrated and fed back to staff compliments and suggestions from patients, relatives and in some cases professionals.

Is the service well-led?

Requires Improvement ↑

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

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.

There was a clear leadership structure within the department and the divisional management above. The lead nurse and doctor carried out their clinical practice in the department and fully understood the pressures that it was under. They were present, visible and available to staff.

They had the appropriate levels of operational knowledge to lead the department in pressurised circumstances. There was an emergency care consultant who was responsible for clinical care in the department, and who worked alongside the matron to provide local leadership direct to the emergency department (ED) team. Each shift had an identified Emergency Physician In Charge who was responsible for the running of the department and making key decisions. There was also a senior nurse identified for each shift responsible for nursing leadership. The senior leadership team met on a monthly basis to discuss quality in the department. They shared learning and good practice and standardised documentation and new processes across both trust ED's.

Junior staff spoke positively about their managers and in turn they were proud of the people they led. Leaders were fully aware of the challenges facing the department and they were articulated consistently by senior staff. These were mainly about the flow through the department.

There was good visible leadership and staff felt supported despite the ongoing pressures in the department.

Staff development was encouraged at all levels and senior staff told us they were proud of the department's ability to 'grow their own' senior staff. Nurses told us they were encouraged to apply for more senior roles within the department.

The managers told us that the previous staff survey had said that staff felt undervalued and had no professional development. Therefore, they had recently brought out rotational posts for band 6 and band 7 staff nurses to go into and offered other training support. These short-term rotations enabled staff to gain leadership skills and insight into the nurse in charge role. This enabled staff to develop their clinical and leadership skills in an area where they already had a good working knowledge and the support of good teamworking.

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.

The trust strategy was 'Putting Patients First'. They used this to develop a 'Clinical Services Strategy to 2025'. The document set out the clear roles for the hospitals including moving all hospital births, inpatient children's services and emergency surgery to the Worcestershire Royal Hospital site which had been completed. The strategy for urgent and emergency care stated that by the end of 2021, they would have embedded a frailty sensitive approach across the hospital and specialities. This included more generalist medical roles across the local system to support people who were frail and complex. We saw that there was provision for the management of frailty within the ED with a separate area supervised by a nurse led geriatric emergency medicine team and that there was specialist support including, for example, pharmacists who were frailty practitioners.

There was a trust wide plan for improving the flow of the patients through the hospital using a continuous flow model and the "boarding" of patients, but it was not working effectively. There was still poor flow through the department which led to long delays for the patients. The pathways that the hospital used to discharge patients promptly into the community were not working as there was a lack of beds in community hospitals and adult social care.

The leaders were working with the Integrated Care Board (ICB) to aid patient flow. The ICB were doing regular reviews in order to facilitate flow within the community.

There was a new ED being built and the department was expected to move in April 2023.

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.

Overall, we observed a positive culture in the department with good working relationships between staff of all seniority and roles. However, staff told us they were very stressed and although this was mitigated by good support initiatives, camaraderie and pride in what they were doing, in private some staff told us they were exhausted and worried about their health. Several staff were tearful when speaking to us. Some senior staff told us that when the problems were escalated to site management, solutions were not provided.

We noted through the matron assurance reports that stress amongst staff was a frequent cause of sickness.

There was a departmental wellbeing strategy developed with local staff but still in line with the trust's wellbeing strategy. Several staff mentioned the difficulty in getting warm food and having somewhere to eat on their breaks. There had been local initiatives to improve the working lives of staff, such as the introduction of a food cupboard with an honesty payment system because there was no food available to staff after 6pm in the hospital. A sleep pod had been provided in the junior doctors and on-call room and efforts were made to protect their breaks.

There was support for staff from the chaplaincy and trust psychologist, the latter in response to staff reporting being unable to "switch off" and sleep when they went home. Some senior nurses had taken a mental health first aid course. There were initiatives to get staff to be with each other outside of the working environment including a team outing and a charity calendar. There was a staff "good news" newsletter which deliberately did not contain any clinical material and reported on news in and outside of work including families.

There had been an increase in violent and aggressive incidents and there was an awareness campaign to improve incident reporting. There was a system in place to respond to incidents of violence and aggression which balanced fairness to the perpetrator with the safety of staff. This was a formal process to escalate from verbal warnings, through a caution letter until a "red card" prevented the patient from attending the department unless for a real emergency. Decisions were made at a very senior clinical level with input from the trust's health and safety and security managers. Two patients were currently under this regime. Serious incidents were reported to the police and one patient had recently been prosecuted.

The system required that all incidents were reviewed, and the member of staff was proactively approached by a wellbeing lead and offered support. During our evening inspection a member of staff was struck by a distressed patient and we noted that the following day a wellbeing lead was identifying when the staff member was next on shift and asking their manager to book an interview time for them.

There was a system to report and recognise excellence by staff where peers filled out a recommendation for a person and they received a card and recognition.

Throughout our visit the front door to reception was staffed by security personnel from a private company. On several occasions we saw them interacting to defuse difficult situations and this was valued by staff and patients to whom we spoke.

Governance

Leaders mainly 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 mostly effective to ensure that the service was always safe and performed well. The ED had joint weekly governance meetings with the Alexandra Hospital ED senior leadership team. They reviewed performance, incidents, complaints and audits and had common themes across the directorate. They investigated serious incidents which happened in the departments and shared learning.

Senior departmental meetings took place monthly and involved the consultant medical staff and senior nurses. We saw from the notes of these meetings that they discussed clinical governance, mortality and morbidity, specific incidents, recent audits and matters arising. The topics discussed correlated well with issues of which that staff and managers had told us. In addition, there were weekly directorate consultant meetings. These meetings were supported by exception reports that identified concerns and highlighted successes.

There were weekly nursing quality check audits that covered essential safety and quality indicators, such as personal protective equipment, uniforms, infection control, documentation, risk scoring, patient comfort and COVID-19 testing.

Regular audits were completed to assess and monitor the quality of care. However, we did not always see that there was an action plan with the audit. The trust provided audit data following the inspection, but action plans were not provided therefore, it was unclear if the audits were used to initiate improvements within the department.

The governance support to the department had been increased and we noted the introduction of monthly matron assurance reports for the department. These were comprehensive and included incident data, the risk register, falls data, training and appraisal data and audits scores. They also incorporated the trust's Safety Quality Information Dashboard which reported on any harm caused by untoward incidents as well as key audit results.

There was clear and consistent correlation between the issues discussed in the governance meetings, those identified through the reports we saw, what staff told us, and what we observed.

There was a lack of oversight regarding medicines management within the department. We found instances of medicines that had been left out or in clinical areas or were not needed and had not been destroyed.

Management of risk, issues and performance

Systems to manage risk, issues and performance were not effective due to capacity and flow issues. However, they identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The department monitored the risks present in the department on a day to day basis, as well as at a more strategic level.

Significant and ongoing risks were recorded in a "risk register". The risk register had the highest risks for the department as overcrowding and exit block, ambulance off-loads and the safety of the waiting room. These were classified as "extreme" risks, and this correlated with what we saw and were told.

Workforce gaps, the safety of side rooms, IT hardware, aggression, the care of mental health patients for long periods and delays in referral were rated as "high".

Corridor care, fire evacuation, delays to triage and doctor's access to medicines were "moderate".

These risks had associated action plans and mitigation. However, while the mitigating actions improved safety, for the patients who were waiting a long time in the department, they did not effectively address the underlying problem of moving patients out of the department.

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.

ED mortality and morbidity meetings took place monthly to discuss any deaths which had occurred unexpectedly in the ED and were used to identify learning and reduce risks to patients. The notes of departmental meetings showed that cases had been discussed and reviewed in August and October 2022, although because the September meeting was not quorate the cases were held over to the following month. Cases were also discussed at the serious incident review and learning group. This was a multidisciplinary and cross-divisional governance meeting. If a concern was found, a comprehensive investigation was completed.

When we asked for the information needed for the department to respond to a major incident, we were directed to the incident cards which were readily available. We also asked for the major incident (MAJAX) plan, but this could not be readily obtained, and a copy had to be fetched from outside of the department.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The department made good use of the data that was available to them through electronic records systems. We saw information being presented in understandable formats and processes that had been developed to operationalise that data. We saw that key information was highlighted in various governance reports.

Within the department the staff relied on electronic record systems including their electronic patient record system which was able to be modified to adopt new working practices. This meant that the recent Global Risk Assessment Tool forms were available electronically and integrated with National Early Warning Score (NEWS). We noted that the presentation of notes and key information, such as sepsis and other risks, as well as NEWS and other assessments was very clear on this system. It was in constant use for the management of individual patients and the department as a whole.

We further saw, through the reports and data sets that we requested that this information was used to measure performance against trust and national targets through both audits and “dashboards” that presented the data, sometimes in “real time”. We saw senior staff using this information to monitor and respond to the current performance of the department.

We saw, through the information available to CQC that the department submitted the necessary notifications and reports to external bodies such as the National Learning and Reporting Service and the Strategic Executive Information System.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff had been asked to complete an annual survey. We saw that the managers acted upon the results and made changes within the department.

The department gathered patient views and reviewed these on a monthly basis. All patients who were discharged from the department received a text message, where possible, to ask their view on the service. The department met the trust response target for the Friends and Family Test. The majority of negative feedback from patients was that the waiting times were too long, and this also drew the largest number of formal complaints.

The service was working with commissioners to improve access to emergency care. The ICB were completing regular reviews to help facilitate flow into the community.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

We saw, through the notes of management meetings, that there was a culture of improvement and innovation in the department with suggested improvements being tried and evaluated.