University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Lancaster Infirmary

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Lancaster Infirmary

Inspected but not rated

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below:

Lancashire and South Cumbria.

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.
We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care.
We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered the all of the North West area, including Lancashire and South Cumbria, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services.

However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers.
People who called 999 for an ambulance experienced significant delays.

Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

Our findings

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night.

Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

The Royal Lancaster Infirmary (RLI) provides a range of acute hospital services in the locality of Lancaster, England.

We carried out an unannounced focused inspection of The Royal Lancaster Infirmary urgent and emergency care services (also known as accident and emergency or A&E (Accident & Emergency)) between the dates of 8 and 9 March 2022.

We had an additional focus on assessment units including the surgical assessment unit (SAU), and the acute medical unit (AMU), the ambulatory care unit (ACU), the priority assessment discharge unit (PADU) and the same day emergency care (SDEC) as part of the emergency and urgent care pathways.

As this was a focused inspection, we only inspected parts of our five key questions. This was as part of a CQC national programme for urgent and emergency care system inspections. This inspection was partly undertaken due to the concerns this raised over how the organisation was responding to patient need and risk in the department and to determine how the flow of patients who started their care and treatment in the emergency department was managed in times of high pressure.

The emergency department was previously rated as requires improvement overall. For this inspection we considered information and data on performance for the emergency department and assessment units.

- The service controlled infection risk well. Staff had training in key skills understood how to protect patients from abuse, and managed safety well. The service used systems and processes to safety prescribe and administer medicines. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- The service provided care and treatment in line with national guidance and evidence-based practice and staff worked well together for the benefit of the patients. Patients were supported to make decisions about their care and had access to useful information. Key services were available seven days per week. Patients were given pain relief as they required it.
- Staff treated people with compassion and kindness and took account of individual needs. Staff provided emotional support to patients, families and carers to minimise their distress.
- The service planned care to meet the needs of local people. People could access the service when they needed it, however they could sometimes wait longer for treatment.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. Most of the time leaders and teams used systems to manage performance effectively. Managers identified actions to reduce the impact of identified risks. All staff were committed to improving services continually.

However

Our findings

- People did not always receive the right care promptly due to pressures on capacity of the service.
- The emergency department (ED) premises did not consistently meet the needs of the patients and staff to maintain safety, privacy and dignity.
- The service did not always have enough medical, nursing and support staff, nursing with the right qualifications, skills, training and experience.
- The service did not always manage patient safety incidents well.
- Not all staff felt supported and valued, all the time. Staff felt concerns they raised were not always listened and responded to.
- Medical staff from other specialities and assessment units did not always work well with the emergency department to achieve the best outcomes for patients.
- The arrangements for prescribing, recording and storing of medicines were not consistently safe.
- The service did not always follow national legislation and guidance for patients lacking capacity.

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills including, the highest level of life support training to all staff. Not all staff who required Advanced Paediatric Life Support had achieved this.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The service recognised that training compliance had been impacted by COVID-19 rules and had implemented a tracker to monitor training. Minutes of meetings highlighted to staff the need to be aware of an increase in their own training and recognised the barriers to this.

The mandatory training was of a satisfactory level and met the needs of patients and staff. The trust target for mandatory training compliance was 95% for all staff training. This was met for: Conflict resolution, equality, diversity and inclusion, fire - general fire safety, health and safety, infection prevention level one, manual handling (modules A and B), information governance, and safeguarding children and adults level 1.

Information received from the trust following the site visit showed that improvements in the rates of training compliance were noted across the trust's emergency departments. The service had not achieved the set targets for overall mandatory training. From November 2021 to January 2022, the rates of training compliance were 81.1% which was lower than the trust compliance target of 95%.

There was an overall improvement in staff completing their core skill training. The trust told us that clinical staff in ED undertook paediatric resuscitation training annually at a level applicable to their clinical role. Consultants, senior medical teams and senior nurses at band 6 or above attend Advanced Paediatric Life Support training. Junior medical staff and band 5 registered nurses undertake Paediatric Life Support, assistant practitioners and health care support workers attend Paediatric Basic Life Support.

We noted that 85.7% of the doctors working in the ED had an advanced life support qualification which meant, there was always a doctor on duty with this training and qualification.

All paediatric nursing staff had completed their advanced paediatric life support qualification, which meant there was always a nurse on duty with this relevant training and qualification.

Additional information showed that 50% of staff at band 6-7 had current Advanced Paediatric Life Support qualifications. For those with training and a booked course this was a total of 66.7%. The information supplied by the service did not demonstrate all staff at band 6 and above had training in advanced paediatric life support.

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.

All staff received training specific for their role on how to recognise and report abuse. Reporting of safeguarding concerns was reviewed, and feedback was given to staff to assist with learning. There was support for safeguarding of children from a paediatric nurse who led on safeguarding and delivered training. The data provided by the trust indicated a slight decline in compliance rates in January 2022 compared with October 2021.

Staff spoken with, gave examples of how to protect patients from harassment and discrimination including those with protected characteristics under the Equality Act 2010. There was support available from the safeguarding team who told us that staff made appropriate referrals. The need to be aware of safeguarding was embedded in the staff's understanding with appropriate action taken as needed.

Staff knew how to identify adults and children at risk of, or suffering, significant harm such as; female genital mutilation (FGM) and child sexual exploitation (CSE). Staff worked with other agencies to protect them. Reception staff were alerted when booking in a child or an adult as to whether there were any specific safeguarding needs as there was a flagged alert on the patients' record.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could contact the safeguarding team from 9am-5pm, Monday to Friday if required. The trust intranet site contained guidance to support staff for out of hours support.

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.

During this inspection we observed all areas visited were clean and had suitable furnishings which were clean and well-maintained. Areas such as chairs and flooring, were easily cleaned and wipeable to assist in the prevention of the spread of infection.

Managers audited staff compliance with infection control practices as part of a wider COVID-19 assurance framework. Staff compliance was reported to infection prevention and control specialists within the service and actions needed were fed back to staff in the department. Managers monitored and reviewed all areas of the department each month and documented areas that needed more cleaning or repairs. This information was fed back to cleaning or maintenance staff for action.

All staff were observed to follow infection control principles including the use of personal protective equipment (PPE), being bare below elbows and wearing surgical masks. Staff wore disposable gloves and disposable aprons when they were required, for example, assisting patients with personal care. Hand hygiene audits were completed every two months. In December 2021, the audit showed 80% of staff were meeting hand hygiene compliance which was an improvement from September 2021 when the audit showed 60% compliance rate in the audit. Training for hand hygiene showed minor variation between October 2021 when the service achieved 90.4 % and January 2022 when the training rates for hand hygiene had been 90.5%. However, there had been a clear increase in training rates in November 2021 when the service achieved 92.3% and December of 91.4%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There was a cleaning checklist in place to ensure that all areas of patient bays were thoroughly cleaned after each patient had left. However, the cleaning schedules pre-dated the advent of COVID-19 and did not highlight high touchpoints such as door handles and corridor handrails.

Urgent and emergency services

Staff screened patients for signs and symptoms of COVID-19 when they attended the emergency department. These actions supported the service to arrange for patients to be cared for in different areas of the department and reduce the risks of the spread of COVID-19. If patients tested positive, they were placed in isolation cubicles. In majors, doors had been added to the COVID-19 positive cubicles to reduce the spread of infection. There was a separate, walled COVID-19 positive bay in the resus area. Additionally, there were isolation rooms that could be flexed to accommodate the number of patients testing positive for COVID-19. When a patient was allocated a certain cubicle because they had tested positive a red sign was added to the door to alert staff and make sure they took the appropriate precautions to maintain the safety of all patients within the unit. There was quick point of care testing in place for those patients who may be presenting with COVID-19 symptoms with a turnaround time of around 10 minutes to obtain the test results.

Staff cleaned equipment after patient contact. However, the labelling such as “I am clean stickers” on equipment were not in use. Disposable curtains/ screens were available throughout the department and these were dated when they were replaced to ensure the department could replace these frequently and assist in the prevention of the spread of infection.

There was a domestic team in the department to deep clean COVID-19 or suspected COVID-19 positive areas after each patient had left. We saw that when patients who had tested positive for COVID-19 left a cubicle, deep cleaning started rapidly to make sure that waiting patients needing a cubicle could access these areas as soon as practicable.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, the premises did not meet the needs of the patients and staff to maintain safety.

Patients could reach call bells and staff responded quickly when called. However, some patients were cared for in areas where there were no call bells. This included patients who were being cared for in an area referred to as a ‘sub waiting area’ and patients being cared for on trolleys in the corridors within the ED. However, the ‘sub waiting area’ was close to the main hub/nurses’ station and could be overseen by staff walking around the department. For patients being cared for in the corridor, suitable staff were allocated to support these patients.

In SDEC, three patients could be supported in an examination room with access to a call system. These patients could be observed by staff on a frequent basis or on a one to one allocation dependent of patients’ assessed needs. Patients in AMU had access to call systems as needed.

The provision of waiting and treatment areas for children was not ideal in terms of safety. However, there was an improvement since the previous inspection; the service had created three cubicles for a separate treatment area monitored by paediatric nursing staff. The children’s waiting area had been separated from an adult waiting area. However, this was inside the area for the adult minor’s area and adjacent to a mental health provision. The waiting area was not in the line of sight of staff and made clinical oversight of children difficult. Staff recognised this and mitigated the risks where possible by observing the area at intervals during the shift. This was not always possible in busy periods or when paediatric staff were not available. However, in general children usually attended the department with a responsible adult who may assist summoning support.

The design of the waiting area for walk-in patients presented a risk to patients who may deteriorate whilst waiting to be seen. The triage nurse in the waiting area performed the triage through a window of the reception office and had no direct access to the patient. We observed that, after each triage, the window was closed and there was no direct observation of patients in the adult waiting area.

A separate area known as the annex was available for adults with mental health needs. The annex was ligature free and had furniture in line with mental health guidelines. There was the ability to put a bed in the room, instead of a chair or trolley, when needed. This area was staffed by mental health liaison nurses from the local mental health trust with support from the service mental health nurses. The annex could not be used for unstable patients. The annex was not suitable and had not been used for patients under 16 years of age with mental health needs. Children with mental health needs were supported in the paediatric area accessed by all under patients aged under 16.

We observed that all areas we visited had enough suitable equipment to help staff safely care for patients. Staff carried out daily safety checks of specialist equipment. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was. We saw that daily checks of the trolleys had been completed. Defibrillators and other equipment had undergone electrical safety testing to ensure they were safe for use.

The service had a separate major incident equipment stored area and a decontamination unit external to the department. Equipment was checked and was well-ordered, clean, labelled and was in date.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal. We saw waste management systems were in place to ensure waste was appropriately disposed of. Clinical and non-clinical waste was sorted into colour coded bags.

There were specific sharps disposal buckets for sharp instruments such as needles used for injections. All the sharps containers we saw were free from protruding needles and stored safely. However, we noted that adjacent to the children's waiting area there was an unsecured trolley that contained sharps such as needles which could present a potential risk.

Assessing and responding to patient risk

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

During this inspection we found that staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations and to assess for sepsis (severe reaction to an infection) for adults and children of different ages in accordance with national guidance. Observations for adults National Early Warning System (NEWS2 (National Early Warning Score2)) was in use and a paediatric early warning score (PEWS) system was in use for children. Both these systems scored medical observations such as pulse and blood pressure to determine the needs of patients for additional medical support and prompted staff to seek the correct support. This information was logged and shared to allow staff to have oversight of the clinical risk of patients in the department.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly.

We reviewed a total of 33 patient records and saw that observations were undertaken in accordance with the needs of the patients. Patients waiting to be seen received observations in line with the department's protocols, patients waiting to attend a ward received observations in line with ward protocols.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The Royal College of Emergency Medicine guidance on the initial assessment of emergency

patients (2017) states face to face contact with the patient should be performed in an environment that has sufficient privacy to allow the exchange of confidential information and that the assessment should be carried out by a clinician within 15 minutes of arrival. We saw that records reflected, on average patients were triaged (the sorting of patients according to the urgency of their need for care) in a timely manner. We did see that two children were not triaged in a timely manner and remained in the adults waiting area as opposed to the area designed for children, including one for just over two hours and one for 45 minutes. The service addressed this promptly and supplied the following information also circulated to their staff, "Children are to be picked up in time order and urgency of presentation. If the paediatric nurse has picked the patient up, they are to communicate this to the triage nurse, otherwise, the triage nurse should assume when they are triaging, they are picking all patients up in time order." A sample review of records showed that this delay was not a common event.

The average handover time from an ambulance to the staff in the unit from arrival during the week commencing 7 March 2022 was 23:47 minutes. Handovers within 15 minutes had a national target of 65%. The service at Royal Lancaster Hospital achieved 43% in under 15 minutes which was 22% below the target. Handovers in under 30 minutes were at 84%, 11% below the target of 95%. The longest amount of time from arrival to handover from the ambulance team that week was three hours and 41 minutes. The service received an average of 44 patients by ambulance every day. As a result of the pressure of admittances the service was not consistently able to meet targets.

Ambulance handover records showed that on average patients were being handed over and clinically assessed within 15 minutes of arrival and ambulances were able to clear the department to attend another call. Ambulance crews told us that there were few delays in handing over patients when they arrived at the department. If the department was busy there was a bleep system available so the ambulance staff could appropriately support the patient until there was room within the department. Patients remaining in ambulances were monitored by the ambulance crew and staff.

Information from the trust showed that in December 2021 the service met the 15 minute triage at 78.70%, in January 2022 this was 84.51% and February 2022 this was 80.03%. The longest time from arrival for triage was on 18 January 2022 of 133 minutes. The service did not consistently meet the 15 minute target for all children.

Risk assessments were used to record and act on risks of reduced skin integrity, falls, venous thromboembolism (blood clots), safeguarding vulnerability or delirium (confusion). The patient record system prompted staff to consider these risks and provided instructions should the risk be present.

Sepsis screening tools were in place. There was a sepsis trolley in the department so that sepsis treatment could be initiated quickly. The department had its own blood gas machine to support a prompt diagnosis. Staff received training in how to recognise signs and symptoms of sepsis. During the COVID-19 pandemic to alleviate pressures on NHS services and allow staff to prioritise clinical need, NHS trusts had received guidance that, as a temporary measure, audit data collections would not be mandatory. Managers reviewed which audits were essential to provide assurance on treatment provided, which included continuation of the audit around sepsis care and treatment. Information sent from the trust showed that staff training rates in recognition of sepsis was 84.5% in January 2022, which was below the trust compliance target of 95%.

Data supplied by the trust showed the training rates for paediatric basic life support training was 74% in January 2022. This was lower than the trust compliance target of 95%. Managers were aware of the reduction in training rates and were monitoring this to ensure that more staff could be supported to undertake the training as needed.

There was always a consultant in the hospital with advanced paediatric life support training who was either in the department or on call.

Urgent and emergency services

Staff knew about and dealt with any specific risk issues.

There had been an improvement in the stoke pathway. For patients with a suspected stroke a computerized tomography (CT) scan was undertaken to identify whether the stroke was caused by a bleed. If no bleed was detected, they then required a CT angiogram to check whether there was a blood clot. This would be treated by thrombolysis, using a clot-busting drug to disperse the clot and return the blood supply to the brain. We saw that stroke patients were prioritised for access to the CT scan and this was undertaken in less than an hour from arrival in the department.

Shift changes and handovers included all necessary key information to keep patients safe. There were ongoing meetings that representatives of the department attended to highlight and mitigate risks or events identified that day. We observed a handover which was clear and included relevant information and discussion about patient treatment. There were also planned safety briefings for all to attend during their shift.

There was a consultant in the waiting area, assisting the triage nurse who could order blood and ECG tests and they were supported by a clinical support worker who would facilitate the tests which were happening in a timely way.

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. There were two mental health nurses always on duty these were employed by a Mental Health trust and worked in the Annex of the ED department. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide as part of the triage on admission and referred them directly to the Annex in the ED which was a specifically designed area to meet mental health needs of patients needing this support. The Annex was staffed by mental health staff for a local mental health service.

Mental health support was available 24 hours a day for patients aged over 16 years. There was no provision onsite for patients aged under 16. Contact was made with the relevant mental health trust prior to admittance if the patient needed children and adolescent mental health services (CAMHS) support. If there was a patient in the department their medical were addressed prior to transferred, to a service to meet their mental health needs.

Staffing

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

The ED did not consistently have enough nursing and support staff to keep patients safe.

Managers calculated and reviewed the number and grade of nurses and clinical support workers needed for each shift in accordance with national guidance. The department manager could and did adjust staffing levels daily according to the needs of patients. However, these numbers were not always achievable. At times of additional pressure patients were cared for on corridors. When this occurred, there was a ratio of one nurse to four patients planned for, but this could not always be maintained. Managers told us they tried to prioritise the patients with greater needs and risks to be cared for with a ratio of one to four. We saw that during our inspection the department was at over occupancy, this included patients who were able to sit, the cubicles and the corridors. Staff told us that they had worked at this demand level for several weeks. We saw that patients on the corridors were checked appropriately and personal care and support was provided to meet their needs. The service was aware of the risks of having patients on the corridors and had plans in place to reduce the impact of risks. However, told us that they did find this difficult at times.

The ACU and SDEC units were in operation from 8am until 8pm. If a patient on SDEC still required support after 8pm, the intention was that they returned to ED or were admitted to the hospital. We saw that on at least one occasion staff on the SDEC unit had had to remain until 11pm as the ED was too full to take the patient back. Staff on the SDEC unit also supported the ACU. As a result, the staff had overview and care responsibilities of all patients on a trolley, in an examination cubicle and all patients seated. The staffing ratio was determined as eight nurses and five clinical support workers. However, records showed, and staff told us, ACU and SDEC frequently operated with seven nurses and on the day, we were on site there were six nurses.

The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) states every emergency department treating children must be staffed with two registered children's nurses. The department was not able to fully achieve this. However, the service tried to ensure there was always one full time band 6 paediatric nurse on shift covering the children's emergency department. It also tried to ensure it provided two paediatric nurses on duty from 5pm to 8 pm to cover the peak time for paediatric admissions four times a week. We saw that the service was not always able to maintain 24-hour paediatric nursing on 7 March 2022 as there was no paediatric nurse overnight due to short notice absence.

There was a paediatric unit within the hospital and nursing staff were requested to support the paediatric nurses as needed. A standard operating procedure to formalise this support arrangement between the ED and paediatric wards had been developed but was not yet in operation. Some patients were diverted directly to waiting areas within the paediatric wards without needing to be admitted to the emergency department. The service took this action whenever appropriate. Additionally, the service had other members of staff available who had training in paediatric life support.

The ED and ACU/SDEC did not have a dedicated pharmacist, however the service had plans in place to address this. In PADU there was a dedicated pharmacist who assisted in ensuring the correct medicines had been prescribed to support the rapid discharge of patients.

The use of bank and agency staff was limited and staff familiar with the service were requested. In the six months prior to inspection, agency nurses had been used in ACU for 2.95% of shifts and ED, 6% of shifts. Bank staff were used across all areas with the highest usage of bank staff used in ACU (29.5%) and ED (30.15%). The service had experienced high absentee levels due to COVID-19. All bank and agency staff received an induction and their performance was monitored. Managers told us they had an approved business case to recruit more staff and taking their existing whole time equivalent of staff into account the department would be slightly over the required numbers.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience. The need to monitor the provision of medical staff was recognised by managers who regularly reviewed staffing levels and skill mix to manage any potential risks and provide medical staff with appropriate support. Monitoring of staffing levels was undertaken to keep patients safe from avoidable harm and to provide the right care and treatment.

In September 2021, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the service was lower than the England average.

The staffing skill mix for the 49 whole time equivalent staff working in urgent and emergency care at the University Hospitals of Morecambe Bay NHS Foundation Trust was as follows: whole time equivalent for consultant level was 18%

in total, which was below the England average of 29%. The middle grade level was 54% in total, which was above the England average of 15%. The registrar grade level was 18% in total, which was below the England average of 36%. Junior grade level was 10% in total, which was below the England average of 20%. *(Source: NHS Digital Workforce Statistics).* This was for all emergency departments and could not be separated between separate locations.

This meant that there was increased staffing within the middle bands, to offer opportunities to support consultants and develop their own staff.

Data showed that there was a low usage of agency locums for middle grade doctors, it was 4.85% of shifts. Agency locum consultants were used for 13.7% of shifts.

The service had recognised the need for an increase in the number of consultants above the establishment of eight consultants in the Royal Lancaster Infirmary, three of which were long-standing locum consultants. The department had determined it required 14 consultants and was therefore actively recruiting for a further six consultants. To meet the needs of the population additionally skilled doctors had been recruited above the national average for the middle grade level to support the consultants in post. Middle grade doctors have developed all the skills as a doctor to support them to undertake a specialised training programme. Additionally, there was a development programme for doctors to assist in developing the skills in becoming consultants within the service to assist in the recruitment and retention of medical staff.

The service had determined its four busiest times to be Friday, Saturday, Sunday, and Monday night from 5pm to 2am and had recruited a paediatric emergency specialist to cover those busy periods and assist in meeting patient's needs. The paediatric unit provided medical support when a child required treatment and clinical decisions to be made when the paediatric emergency specialist doctor was not on duty. A standard operating procedure had been developed to support this arrangement. However, this had not yet been agreed or adopted into practice.

Medical support was provided to SDEC from 8am until 5pm. For patients remaining in the unit after 5pm assistance could be given by medical staff in the ED and adjacent medical assessment areas.

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 easily access them. We reviewed 33 individual patient records and found them to be well completed, in line with trust and professional standards with assessments, observations and treatment recorded.

There was also a separate paper record for recording observations about patients who were still waiting to be seen, for example, waiting in a corridor. These were used to assess the risks and monitor the patient. Records were transferred with the patient to the wards as needed.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. However, in ACU and SDEC we saw that some records were available in an open trolley kept next to the reception/nurses' station. These records did contain some details that were personnel to the patient and were in an area that could be accessed easily. This was also identified as a concern at the last inspection.

Urgent and emergency services

Medicines

The service used systems and processes to safely administer medicines. The arrangements for prescribing, recording, and storing medicines were not consistently safe.

Staff completed medicines records accurately and kept them up to date when administering medicines. Records we reviewed showed medicines were normally given on time and accurate records had been made.

Medicines were not always safely stored. Medicines stocks were stored in appropriate cupboards and medicines fridges. Patients on a trolley in a corridor had their medicines stored on the back of the patient trolley. The trust confirmed there was no overarching risk management assessment for this or individual plans. We were told by managers that it would depend on the capacity of the patients to manage their medicines. However, this was not available in guidance to staff.

There was no clinical pharmacy support in ED to help clerk and reconcile (check) patient's medicines, but we were told a business case was in progress to help improve this.

Controlled drugs were not always handled safely. A controlled drugs book was used to record when these drugs entered the department or were given to people, however, it had gone missing. As a result, the service could not be assured as to when and to whom these drugs were given for the previous two months. Controlled drugs are drugs that are subject to important levels of regulation because of government decisions about those drugs that are especially addictive and harmful. This was being investigated by the service to determine any lessons to be learnt. Controlled drugs records had not always been completed as per trust policy despite enhanced audits and procedures.

Bottled oxygen was used for patients on trolleys in the corridor. Records showed that the cylinders were checked as part of the patient observations to make sure they had enough oxygen remaining in the cylinders.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents. Managers reported 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 were not clear about what incidents to report. All staff knew how to report an incident. Staff did not always raise concerns or report incidents and near misses in line with trust policy. On the ACU/SDEC unit when staffing levels had fallen beyond the agreed staffing levels this was not always reported. Significant stays within the ED or delays to treatment whilst awaiting a specialist were not always reported as an incident. The trust gave us information where paediatric patients had not been triaged within 15 minutes whilst this data was available these failings in triage were not consistently incident reported when triage was not undertaken within 15 minutes. This meant lessons were not always being learned from these incidents.

Where inappropriate referrals from GP's had been made to any of the units these were not reported as an incident. It was explained that if the patient had contacted the out of hours GP support the service was unable to track the referrer. However, without monitoring inappropriate referrals the trust would not be able to supply the information to GPs to support the GP's learning and development and reduce inappropriate referrals to the service. Managers told us that although significant inappropriate referrals were incident reported, not all inappropriate referrals had been reported.

Urgent and emergency services

Managers shared learning with their staff about never events that happened elsewhere. Bulletins highlighting learning were available on the unit, discussed at team meetings and available on the intranet. Team meetings included reference to incidents under investigation and any complaints made.

Staff reported serious incidents in line with trust policy. Serious incidents were investigated, and proper actions taken following these incidents. Following a serious incident for care on the corridor, the service had made sure that care of patients on corridors was made a priority. Staff had received feedback from this investigation and management had shared the relevant learning. During the inspection there were two ongoing investigations in relation to a missing controlled drugs book and a patient inappropriately accessing their medicines.

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

There was evidence that changes had been made because of feedback. Examples included response to the last report had improved care for patients diagnosed with a stroke. However, there was limited information as to how managers reviewed incidents and checked for any patterns and trends to aid in preventing incidents reoccurring. As some incidents were not reported it would be difficult for managers to assess these and make sure they could make positive changes as a result.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Inspected but not rated

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. We noted there had been an improvement in the stroke pathway. Pathways and policies were based on guidelines and standards set by organisations such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). The documents were easily accessible to all staff on the intranet. There was a clear list of common emergency presentations and comprehensive guidelines and pathways to manage these conditions. Mental health assessments were completed in a prompt way to ensure that the right level of support was put in place.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. There were staff available in the emergency unit and on site to assist. Of the records viewed we saw the Mental Health Act had been implemented correctly. Further information is covered in a separate report specifically for mental health provision within the Royal Lancaster Infirmary.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Urgent and emergency services

Nutrition and hydration

Staff made sure patients had enough to eat and drink. Hot food trolleys were available at frequent intervals during the day and all patients spoken with said they had received food and drink during their time in the emergency department.

Pain relief

When patients said they were in pain this was promptly addressed. There were records available that showed the management of pain and the prescribing of appropriate pain relief was include in the patient's treatment plans.

Patient outcomes

The trust took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). The Sentinel Stroke National Audit Programme aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. These standards are informed by the National Clinical Guideline for Stroke, and national and local benchmarks. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, July to September 2021. Overall, the outcomes for patients diagnosed with a stoke had improved.

Patient outcomes were gathered from the completion of Royal College of Emergency Medicine (RCEM) national audits. The audits included mental health outcomes as well as fractured neck of femur (broken hip).

Multidisciplinary working

Doctors, nurses, and other healthcare professionals in the department worked together as a team to benefit patients. They supported each other to provide good care. However, the emergency department, medical staff from specialities and assessment units did not always work well together to achieve the best outcomes for patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Handovers took place with nursing and medical staff to share information about the status of the department and address any issues. Staff were allocated to different areas of the department but supported each other and moved if one area was particularly busy.

However, there was a reluctance by assessment areas and speciality teams to accept admissions in a prompt way from the emergency department. We saw instances when the admittance to relevant assessment units had been denied and lengthy delays, with one example of up to 42 hours, the patient was treated by a surgeon in the department and discharged directly home from the department. Staff and managers told us they found this a frustration, as this resulted in patients not moving out of the department promptly. There was a standard operating procedure in place to assist in this multi-disciplinary approach, but this was not consistently adhered to.

Staff worked across health care disciplines and with other agencies when needed to care for patients. The frailty team was based next to the ED and assessed patients, gave advice, and put measures in place to keep patients safe whilst in hospital and when they were discharged from hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff worked closely with the mental health liaison team who were based next to the emergency department.

We spoke with ambulance staff who told us they had good working relationships with staff in the department.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always follow national legislation and guidance for patients lacking capacity.

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 did not monitor how well the service followed the Mental Capacity Act as there were no arrangements to check if mental capacity assessment or best interests had been implemented correctly.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There was no information available as to what training staff had received. However, staff spoken with demonstrated a clear understanding of their roles and responsibilities in relation to patients lacking capacity.

Staff clearly recorded consent for patients with capacity in the patients' records. Doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination. However, we saw that when patients did not have capacity to give consent, staff did not always undertake a capacity assessment and record the best interest of the patients or update relevant documentation such as do not attempt cardiopulmonary resuscitation (DNACPR). Managers told us that DNACPR was monitored by the safeguarding team but were unclear as to what information they received from the audits.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The 'Gillick Test' assists clinicians to learn if a child under 16 years of age has the legal capacity to consent to medical examination and treatment. The child must be able to show enough maturity to understand the nature and implications of the proposed treatment options, including the risks. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Guidelines for managers in relation to deprivation of liberty state that; a deprivation liberty of safeguards authorisation (DoLS) is not relevant if, in few hours or a few days the person will no longer be in that environment. Some patients are stabilised within the ED, and it is predicted that they will remain in the hospital for some time. The application of a deprivation of liberty safeguards authorisation is not considered until the patient reaches a ward by which point the patient may have been in the hospital for a period more than a few days. The trust policy regarding DoLS did not excluded the ED in recognising and applying a DoLS and states that; it is applied to all patients who are lacking capacity and under constant supervision.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. The service did not consistently maintain patient's privacy and dignity.

Urgent and emergency services

Staff treated patients with compassion and kindness and took account of their individual needs, but privacy and dignity of patients was not always respected. We saw that, when patients were being triaged in the main reception area, that it was possible to overhear the conversation. This was because there was not a secluded area for triage discussions. Additionally, the service had moved the ambulance handover area onto a main corridor. The handover between ambulance and hospital staff could be overheard by patients waiting in that area. We saw that one patient had a lengthy stay in the department resulting in them being sat in a plastic chair for extended periods of time as there was no bed or trolley available for them to use for the duration of their stay. The patient was under constant observation with their medical needs assessed and addressed. Managers were aware of this and had endeavoured to find a more suitable arrangement. This was not possible due to the pressures on the service and the lack of available bed space.

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 spoke with 23 patients across all the areas visited. Patients said staff treated them well and with kindness. Overall, most patients told us they thought the care and treatment they received met their needs.

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. The service had arrangements within the building to meet the religious and cultural needs of patients such as a multi faith chapel on both sites. Religious and faith support could be requested to see patients in the department.

Emotional support

The service assisted staff to provide emotional support to patients, families, and carers to minimise their distress. Staff understood the need to recognise and maintain patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. They understood patients' personal, cultural, and religious needs.

Staff provided emotional support to patients, families, and carers to minimise their distress. Staff considered patient comfort and offered food, fluids, and pain relief when they needed it. Staff showed understanding of how patients might be feeling and explained treatment in diverse ways to help with clarity for patients.

Staff did not have training on breaking unwelcome news but were able to show 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.

Understanding and involvement of patients and those close to them

The service assisted staff to support and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Managers and staff made sure patients and those close to them understood their care and treatment. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Urgent and emergency services

The trust held patient experience meetings to decide how the service they delivered met the needs of patients. Following the site visit the trust sent information from a patient experience group meeting held on 25 October 2021. The attendance of this meeting included several key staff to incorporate the diversity needs of patients. The trust was developing information in different formats to meet patients' differing needs. A review of the patient survey results showed that emergency departments at both sites needed "some support in terms of patient experience."

The patient experience team were planning to review the patient experience in the emergency department ` using observations and patient interviews. The computer system was also going to be utilised to show what information was given to patient, family, or carer as an ongoing narrative of the patient experience. There was also agreed actions to support staff with additional training in relation to dementia care. Patients stories that detailed the patient's experiences and how their journey through the service occurred were submitted to the trust board. As agreed at the patient experience meeting a review of patient experience was undertaken in November and December 2021. There were several positive findings including how staff interacted with patients, that the service was clean and uncluttered. Areas for improvement identified in the plan were maintaining patient privacy as conversations could be easily overheard particularly in reception and waiting areas, information to patients was not always correct or up to date, that the department was busy. However, we found at the last inspection and at this visit that patient privacy remained in need of improving.

The results of the patient experience audit were to be used in making sure that patients and their relative's views were used to enhance the delivery of care and support.

The patient survey of 15 September 2022 for urgent and emergency care showed that 85% of the time patients were given a clear explanation about their condition and treatment and 91% of the time patients felt that doctors and nurses had listened to them.

The feedback from the ED survey test was overall positive. The patient survey results of 15 September 2021 Urgent and Emergency Care from 308 people at University Hospitals of Morecambe Bay NHS Foundation Trust, showed that the service for both emergency departments performed about the same as other trusts.

The trust outperformed other trusts in relation to; patients being given the right amount of information about their condition or treatment, involvement in decisions, explanations, and test results.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service took account of patients' individual needs and preferences. The service had not fully implemented reasonable adjustments to be inclusive to help patients access services with ease.

Staff made sure patients living with mental health needs, learning disabilities and dementia, received the necessary care to meet their immediate needs.

The service was designed to meet the needs of patients living with dementia. A cubicle in the major's area was used specifically for patients with dementia, with input from the lead dementia nurse in the hospital. There were specific areas in place to support children and patients with a mental health need.

Urgent and emergency services

Staff understood and applied the policy on meeting the information and communication needs of patients living with a disability or sensory loss. The trust had a policy in place that outlined how they intended to make information accessible and available to meet patients' independence and a better patient experience. This included; flagging patients in the computer system who needed additional support, providing information in formats to meet differing patient needs. This however had not been implemented to assist patients. The trust stated that they would fully meet the accessibility information standard by summer 2022. The accessibility standard was implemented by the NHS and, it required that from 1 August 2016 all organisations that provide NHS care were legally required to follow the Accessible Information Standard. Specification and Implementation Guidance for the Standard which was published in August 2017. The trust's progress to meeting this standard is not prompt.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it but did not always receive care promptly due to pressures on capacity caused by shortages of available beds within the hospital. Waiting times to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

The service monitored treatment within agreed timeframes and national standards but due to capacity pressures were not always able to achieve them. The service collected data and monitored how many people were in the department, how long they had been in the department and how many ambulances were queueing to handover patients.

Patients received initial reviews within national timeframe standards. Systems had been adapted to increase the number of patients who were assessed within 15 minutes of arriving by ambulance. At the time of our visit we saw most patients had received assessment within this time which was an improvement when compared with performance measures in previous months.

Trust data from September 2021 to February 2022 showed that on average the number of times it was unable to meet the four-hour target was 1,876, the highest peak being in October 2021 when this was 2,126. The amount of times they were unable to meet 12 hours as an average was 158, this was an increase from 111 in September 2021 and 249 in February 2022.

For the most recent month available of January 2022 the total median time for patients in both the trust's departments were 164 Minutes. Patients waiting 4-12 hours from the decision to admit was at 27%.

There were 268 patients who spent more than 12 hours from decision to admit to actual admission and the median time to treatment was on average 51 minutes, which was better than the England average of 65 minutes.

Additionally, flow within the hospital meant that the department was not always able to have bed spaces on wards or assessment units to admit patients to.

On 17 March 2022, 131 patients across the trust did not meet the criteria of right to reside. This meant these patients were medically stable but for distinct reasons not related to their medical needs, they could be discharged from hospital. And therefore, this affected the ability to move patients from ED to wards in a prompt way.

Urgent and emergency services

Managers told us that one of the biggest causes of delays was waiting for medications. As a result, the priority assessment and discharge unit (PADU) had been allocated a pharmacist to assist in speeding up the discharge process. The monitoring of the reasons for delaying a discharge assisted the trust in managing those areas and putting in additional resources to assist in prompt planned discharges.

The service had invested funds in creating an operational monitoring system which monitored each hospital within the trust and the beds available for patients to move through the system. This was monitored closely by staff to make sure they could be aware of what capacity was available in the hospitals. The system was new and provided real time information. However, there were some areas that needed to be embedded such as ward level updating when the estimated date to discharge a patient changed. Without this information the number of patients due to be discharged was not always correct or up to date. There were often long waits for a suitable bed in a mental health facility other than the ED department to become available for mental health patients.

Bed management meetings took place throughout the day to decide what actions could be taken to move patients through the hospital in a manner which met their needs and supported their safety. Escalation triggers regarding bed availability and demands on services were discussed and assessed in accordance with the risk. This information was shared with senior managers.

Prior to our inspection and continuing through the site visit the trust had declared its status as Operations Pressure Escalation Level (OPEL) four. This meant that pressure in the local health and social care system had escalated leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action is be taken to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. OPEL four represents the highest escalation level.

When demand was more than bed spaces, patients were cared for on the corridors. The service had an escalation policy in place for when this needed to be enacted and managed. Staff told us, and we saw that, in general there were patients who needed to be supported on the main corridors. There was significant pressure which meant that patients could not always move from the emergency care department in a timely manner. The trust had added additional assessment review once the patient had received any emergency treatment and the intention was that they moved to either an assessment unit, a ward or were discharged back home.

The service had an overarching action plan to improve and manage the flow of patients through the department and manage issues between ED staff and speciality teams. However, there was a lack of pace in these changes which were not embedded into practice within the trust. Some of the reasons for patients spending longer than they needed to in the department was due to waiting for clinical review and admission to assessment units. Assessment units such as the acute medical unit and surgical assessment unit did not always transfer patients from the ED in a timely manner. There was a standard operating procedure in place, but this was not consistently adhered to. Some speciality services required that they assess patients within the ED rather than accepting them onto their own unit for assessment, which blocked cubicles in the emergency department. Managers told us they would push back and advise the assessment units that they would send the patient to them, but not all staff were comfortable in doing this. Managers told us that bed meetings were not always effective as they did not identify beds that were not available to ED patients.

Managers monitored that patient moves between wards were kept to a minimum.

Urgent and emergency services

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. They were not all visible and approachable in the service for patients and staff.

Leaders had the appropriate range of skills, knowledge, and experience to carry out their roles. The emergency department was part of the medicine care group with a triumvirate leadership team in place. This comprised of a clinical director, associate director of nursing and associate director of operations. At a local level there was a matron and a service lead who were visible within the emergency department.

Staff reported they did not think the leadership team above a local level were visible to them. Other than visits to the unit there was limited information as to how the triumvirate leadership team for the medicine care group were visible. There was limited information regarding who they were and their roles on the units. Staff were highly complementary of the support they received at a local level. They felt less supported by the higher management. Meetings cascaded information both up and down the management structure.

Leadership development opportunities were available, including opportunities for staff below team manager level.

The local leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. They monitored the quality of the service on an ongoing basis and cascaded information as required.

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 service had a clear local vision and set of values. There were five core values, known as the five P's, these being, patients; people; partnerships; progress and performance. There was a strategy for achieving the local priorities and developing decent quality, sustainable care. The vision was displayed on notices. Staff knew and understood the vision, values, and strategy and how achievement of these applied to the work of their team.

As well as an overall trust strategy for 2019-2024 there was a clinical strategy 2019-2024, which contained several objectives relating to the emergency and urgent care model. One of the objectives, to provide a comprehensive model of same day emergency care (SDEC), had been implemented and was in its fourth week at time of the inspection. There were plans to increase both the medical and nursing staffing for SDEC. The initial evaluation of the unit had shown there was a positive impact with the unit having prevented over 280 potential admissions to the ED since opening. However, this unit also supported overflow of patients from the day care unit. There was a criterion for admissions to the unit, but this was not widely understood by ED staff or the staff working on the unit.

Further objectives included areas such as ensuring an enhanced frailty assessment service was in place. This would enable relevant patients to be assessed, treated, and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments with a focus of returning the patient back to their place of residence as a preference to admission. There was a frailty unit in place which was well attended. However, the standard operating procedure to ensure that patients were appropriately transferred to assessment units had not been fully embedded with delays from the ED to assessment units. There had been at least one occasion when a patient had remained within the ED for over 40 hours as the relevant assessment unit had refused to admit them, and the speciality service had not attended the ED for most of the patient's stay. Once the speciality service did attend the patient was treated and discharged from the emergency department.

The local leadership team regularly monitored and reviewed progress on delivering the strategy and plans. This was discussed and monitored within meetings and monitored in the data received. The leadership teams were aware of the challenges and the strengths of the service they provided.

The service had a strategy for meeting the needs of patients living with a mental health, learning disability, autism, or dementia diagnosis.

Culture

Staff felt respected, but not all felt supported and valued all the time. They were focused on the needs of patients receiving care. Staff felt concerns they raised were not always listened and responded to. Patients and their families could raise concerns without fear.

There were mixed opinions from the staff in relation to how supported they felt. All staff spoken with felt they were listened to by the local leadership team, but they did not believe that this was the same with more senior managers. Several told us they felt there were significant pressures on the department that had not been resolved and were unaware of how they were to be resolved. Staff were clear they had been operating for several weeks with a high capacity of patients which meant they needed to provide corridor care.

Between our first day on site and our second there was a marked difference in the number of patients in the department. On the first day the unit was busy with corridor care ongoing, the paediatric area was full on several occasions and all the cubicles were occupied. The area for seated patients waiting for treatment was also full. Staff had told us this was an entirely normal day. On the second day of our visit there were several empty cubicles, no patients on the corridor and no patients sitting to be seen. Managers told us this was due to the OPEL 4 status; different actions such as admitting patients to assessment areas and wards that would not normally be appropriate had been undertaken. Managers told us they would review how this difference had been achieved and try to replicate it as much as possible going forward. They also said they would debrief the staff so that they could fully understand what circumstances had brought about the significant reductions in pressure in the department that they had noticed.

Senior managers told us the culture and working relationship between the emergency department and assessment areas was improving but the arrangements were not yet fully embedded.

The service's strategy, vision and values underpinned a culture which was patient centred.

Staff felt positive and proud about working for the service. Staff within the department reported that working through the pandemic had brought everyone closer and they had been well supported through a challenging time. Staff were enormously proud of the work they did, they demonstrated compassion and a prominent level of integrity to making sure that patients received the best care they could.

The trust had started a wellbeing ambassadors programme to have staff around the service who could support staff wellbeing and offer coaching.

The service had a Freedom to Speak Up Guardian. However, not all staff knew how to use this service, who the guardian was or what their role was.

Staff felt equality and diversity were promoted in their day-to-day work; local teams had positive relationships, worked well together in the department, and addressed any conflict appropriately. This positive local team working was reflected across all the areas we visited.

The service had also supplied support to staff recognising the additional pressures they were under during the pandemic and had continued to implement these. There were arrangements in place for staff who needed additional emotional support, this included a quiet place to be, drop in counselling or support sessions, access to occupational health, yoga, sleep clinic, and cognitive behavioural therapy (CBT) as examples. Overall, there was 40% uptake of this offer from staff.

Governance

Leaders operated a governance process, throughout the service and with partner organisations. Staff at all levels were clear about their personal roles and accountabilities. There were opportunities for staff to meet, discuss and learn from the performance of the service.

The service had effective structures, systems, and processes in place to support the delivery of its strategy. Leaders were clear about their areas of responsibility.

Papers for meetings and other committees were of a reasonable standard and contained appropriate information. There were several audits in place, and these were reviewed in relevant meetings to ensure that the quality of the service could be determined, and action taken as needed.

A clear framework set out the structure of the service, division, and leaders. Leaders used meetings to share essential information such as learning from incidents and complaints and to act as needed. There was a monthly medicine care group governance and assurance meeting attended by the matron, clinical lead, and service manager from each department. This meeting covered a standard agenda following the assurance slide deck from each department.

There were weekly medical lead meetings and a senior nursing group meeting where key messages were delivered from executive and board level and these were cascaded down to staff in the department through the learning to improve bulletin and daily huddles.

Bulletins were sent to staff to highlight learning from events. For example, a bulletin from November 2021outlined lessons for sharing and information of note. The bulletin informed staff of areas of learning to assist in improvement and maintaining safety.

Staff understood their roles and responsibilities and what to escalate to a more senior person.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements.

There was no clear governance channel into the wider organisational management structure that oversaw the paediatric provision in the ED and monitored areas such as whether paediatric patients were triaged within 15 minutes. In discussions with staff and managers it was unclear whose responsibility it was to triage children and if these responsibilities were being met.

Within the ED there was a weekly patient safety meeting to review incidents which were rated moderate or above to agree any requirements to record them as serious incidents and whether a root cause analysis investigation was required.

Staff told us and managers confirmed that there were several inappropriate referrals both from GPs and 111 services. However, there was no reporting mechanism in place to capture these inappropriate referrals and to feed back to the healthcare system to ensure that the learning was available to assist in reducing pressures on the emergency department.

Management of risk, issues and performance

Most of the time leaders and teams used systems to manage performance effectively. Staff and managers identified and escalated most of the risks. Managers identified actions to reduce the impact of identified risks. There were plans to deal with unexpected events.

The departmental clinical lead was well-sighted on the issues facing the department. However, staff reported they were frustrated in mitigating risks to patients by a lack of support from the speciality teams and assessment units.

Staff told us there was a difficulty in referring patients to speciality teams. There was a robust implementation of the escalation plan when the department was crowded. The corridor escalation plan stated that when there are more than six patients being cared for in the corridor, that extra staff should be sought to assist in their care and an incident report should be submitted. The need for corridor care was recognised within the department's risk strategy. The additional staff needed were planned for, but this could not always be met. Managers were aware that incident reports were not always submitted when the numbers of patients in the corridor reached maximum escalation level.

We reviewed the departmental risk register and noted that it contained a description of the risk faced, a risk score, controls in place to mitigate the risk, any actions required and who had ownership of the actions. Risks were reviewed and reported through an assurance framework. The risk of delayed assessment and treatment for patients in an emergency department, which was full because of pressures on the service was present on the risk register.

Managers and staff told us they felt urgent and emergency care were holding a significant amount of risk for the health and social care system across the county which was having a potential impact on all staff and patients.

Although the leaders had an overview of most of the issues facing the department there were no overarching action plans for the department to mitigate the risks and manage priorities. For example, the service had worked with the assessment units and speciality services to try to improve flow through the department but there were no specific plans to address the issues in implementing this effectively. We were told there needed to be a coaching/relationship building exercise. There was a lack of urgency in managing this as the arrangements for utilising assessment and speciality services were not all supported by an agreed procedure and the issues have been identified at several inspections. We were informed that senior leaders were aware of these issues and were aiming to prioritise these arrangements to assist in the appropriate transfer and treatment of patients.

Urgent and emergency services

Staff who we spoke with all said they were very worried about patients being cared for on the corridor in the department. The service had had an incident in relation to the care of a patient on the corridor. Staff described this as a "wake up call" and had seen that there was a significant recognition with plans in place to address these concerns.

There were plans in place for emergencies and other unexpected or expected events. The trust had invested funds in developing a major incidents centre. This allowed a co-ordinated approach between all emergency services in the event of a major incident. When a major event had occurred, this area worked well. There was also the facility to ensure that bronze, silver and gold command arrangements were in place. These arrangements ensured control and co-ordination in planning, preparing and responding to all types of emergencies. There was a robust and up to date major incidents plan that included learning from other NHS trusts and events within the country.

Learning, continuous improvement and innovation

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

The service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

Leaders regularly reviewed and improved the processes to manage current and future performance.

Leaders were satisfied that clinical and internal audits were enough to provide assurance. Teams acted on results where needed.

Staff in the department were committed to improving the facilities and environment for patients living with dementia, mental health conditions and children. There had been an improvement in children's facilities and an effective unit was in place for mental health.

Leaders were able to cite innovation and participation in research which the emergency departments had been involved in and of which they were proud. These included; the care and resilience of staff during the pandemic and the support they gave to patients, each other and local leaders. Children's support had been increased, including nursing, medical support and the facilities within the department. There had been improvements in relation to the pathway for patients having had a stroke and the treatment and planning of this in the ED had increased the service's ability to respond in a timely manner to patents needing this care.

Doctors in the department had participated in COVID-19 research and screened patients into appropriate research trials. Doctors had also been involved in developing a new point of care COVID-19 testing device in collaboration with the local university and had received two external funding awards to support this work.

Outstanding practice

We found the following outstanding practice:

- Support to staff through the pandemic was designed to meet their emotional and welfare needs. Innovative practice and opportunities were available for staff to assist them in their well-being.

Urgent and emergency services

- Staff recruited from overseas and were new to the service worked additional to the staff establishment for six months with an individualised induction and a buddy support to make sure that they were appropriately supported in their new roles.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Royal Lancaster Infirmary - Urgent and emergency care

- The service must ensure that care and treatment is provided in a safe way by the proper and safe management of medicines. Regulation 12 (1) (2) (g)
- The service must ensure that patients are treated with dignity and respect. Including ensuring their privacy and having due regard to any relevant protected characteristics. Regulation 10 (1) (2) (a) (c)
- The service must ensure that all premises and equipment used by the service provider are secure and suitable for the purpose for which they are being used. Regulation 15 (1) (b)(c)

Action the trust SHOULD take to improve:

Royal Lancaster Infirmary - Urgent and emergency care

- The service should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily.
- The service should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system.
- The service should consider ways for staff to have oversight of children waiting to be triaged.
- The service should consider reviewing the advanced paediatric life support to make sure that all band 6 staff have the correct qualification
- The service should consider reviewing the arrangements for the implementation of the metal capacity act and deprivation of liberties safeguarding within the ED department and align the trust policy to the practice.
- The service should review the staffing levels within ACU and SDEC ensuring that staffing levels are maintained and risks to staffing establishment captured and monitored.
- The service should consider reviewing the opportunities for safety incident report and review when and what incidents, staff need to report and monitor that they have the support to do this in an appropriate manner.
- The service should continue with plans to improve staffing levels medical staff to full establishment.
- The service should review the perception in the ED of limited senior and executive visibility, recognition, understanding and support.

Urgent and emergency services

- The service should further explore the opportunities for collaborative working from the emergency department, assessment units and specialist services.
- The service should consider reviewing the arrangements for medicines held by patients particularly in relation to those on trolleys, formalise the process in place and ensure that all staff are aware of the practice needed to maintain patient safety.

Our inspection team

The inspection team consisted of two inspectors, a specialist adviser for emergency care and medicines optimisation inspector. The team reviewed data and information available before the site visit, and information sent from the trust. The team spoke with a total of 25 patients, 28 staff and reviewed a total of 33 records at the site visit to Royal Lancaster Infirmary and undertook observations throughout the areas visited. The inspection was overseen by Karen Knapton, Head of Hospital Inspections.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment