Mid Essex Hospital Services NHS Trust

Broomfield Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Mid Essex Hospital Services NHS Trust employs nearly 5,000 members of staff and provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree (including Witham). The trust provides services from five sites in and around Chelmsford, Maldon and Braintree. The main site is Broomfield Hospital in Chelmsford which has been redeveloped as part of a £148 million Private Finance Initiative (PFI).

Broomfield Hospital is an acute 551 bedded hospital which has an additional 18 contingency beds not inclusive of obstetrics. It is the only hospital location to provide Accident and Emergency (A&E) services. Broomfield Hospital also provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical centre to a population of 3.4 million and an internationally recognised burns service at the St Andrew's Centre that serves a population of 9.8 million.

We inspected this hospital on 19 August 2014 in response to concerns of stakeholders and information of concern received into the CQC. Concerns were raised by stakeholders around the number of serious incidents being reported, learning from incidents, staffing levels and leadership within the A&E Department. There were also concerns around the number of incidents being reported around persons deemed 'at risk' of absconding from the department. Concerns around the assessment and treatment of care provided to people with mental health conditions were also shared with us prior to our inspection.

This was a responsive review undertaken by five inspectors from CQC and two specialist advisors. We were also supported by an Expert by Experience. Only the services within the A&E department at Broomfield Hospital were inspected. We have identified that the service was not compliant with some regulations following this inspection. We have not rated the service as this was a focused inspection however a further comprehensive inspection will be undertaken in November 2014 to determine ratings of all services within the trust.

Prior to the CQC on-site inspection, the CQC considered a range of quality indicators captured through our intelligent monitoring processes. In addition, we sought the views of a range partners and stakeholders.

The inspection team make an evidenced judgment on five domains to ascertain if services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

Whilst we noted some good practice there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Continue to increase the number of permanent trained nurses, paediatric nurses and consultants within the A&E department.
- Embed skill mix assessments for nursing staff to ensure that skill mix is appropriate and ensures the safety of patients in A&E.
- Review the consultant rota to ensure that the minimum numbers of consultants are scheduled on the rota in line with The College of Emergency Medicine guidance.
- Review and improve the management and directorate structure within A&E
- Improve the care provision for mental health patients within A&E.
- Review the use of the room where mental health patients are placed for assessment.
- Ensure that the emergency alarm in the additional majors bays sounds in the correct department.

Summary of findings

- Improve the environment in the A&E department, including paediatric A&E, waiting areas and the majors area, to ensure the safety and treatment of patients.
- Improve governance processes and embed an open culture of reporting, sharing and learning from incidents and complaints to improve the care and experience provided to patients.
- Increase attendance at safeguarding training for all staff and improve safeguarding awareness.
- Ensure that staff receive training to support patients with mental health needs.
- Improve numbers of staff attending conflict resolution training and provide breakaway training.

In addition the trust should:

- Take prompt action to ensure that the children's A&E department is in line with national guidance.
- Review working with the psychiatric liaison services, CAMHS and the local mental health trust to improve the care provided to patients within the department.
- Improve multi-agency working with external agencies including the local ambulance trust and police force around mental health provision.
- Ensure that all staff work together effectively to enhance the experience of the patients, ensuring effective communication at all levels.
- Ensure that risks are assessed and managed within the department.
- Hold meetings in the department to discuss incidents or other governance concerns to staff at all levels.
- Improve the completion of documentation, risk assessments and allergy status for patients within A&E.
- Improve communications from Board to the A&E department.
- Take prompt action to ensure that staff speak to and refer to patients in a dignified and compassionate way.

During this inspection we found that the essential standards of quality and safety were not being met in some areas. As a result of our findings we met with the Chief Executive and Chief Nurse of the Trust on 28 August 2014 to discuss our concerns. We were informed that the trust would address the concerns identified; we were also shown areas that were in the process of being improved since our visit. Therefore we have issued the trust with compliance actions.

We have asked the provider to send CQC a report that says what action they are going to take to meet these essential standards. We will follow up to ensure appropriate action to address the concerns has been taken in November 2014.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We spoke with 21 members of staff from various roles including nursing, medical and support services. We spoke with 17 patients and four relatives who were waiting with their children. The feedback from people we spoke with was mixed. The majority of people we spoke with had positive experiences of using the service. Most felt that staff were caring, compassionate and treated patients with dignity and respect however four patients provided us with examples where they felt they were not treated or spoken to in a compassionate manner by staff. The environment despite being purpose built was not fit for purpose. The department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'. The environment did not enable a safe environment to be able to monitor deteriorating patients or those with a mental health condition who required observation. Lessons learned from incidents were not always taking place and where lessons were shared these were not embedded. The care provided to mental health patients within the department was suboptimal and placed patients at serious risk of harm. At the time of writing this report the trust were taking action to respond to concerns identified around mental health care. There were substantial nurse vacancies. The department was reliant on agency and bank staff to maintain staffing levels. The trust acknowledged the numbers and skill mix of nurses was below the expected level. There were five consultants in post and plans were in place to appoint a further three. This was below the expected minimum of 10 consultants recommended by The College for Emergency Medicine. We observed that the service had established pathways in place to fast track patients with certain conditions. There were systems for staff to refer people for specialist mental health assessments where they were identified as having a mental health issue. The department was consistently meeting the 95% four hour target for adults and was a 92% for children and young people within the two months preceding our visit. Staff were clear on the risks and areas in the A&E department that needed improvements but they did not

Summary of findings

feel engaged or empowered to make changes to improve the quality of service. Staff we spoke with felt that the service had improved in recent months. However the morale of staff in the department was very low.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The Accident and Emergency Department (A&E) at Broomfield Hospital is located within the newly developed PFI wing of the hospital that was purpose built and opened in 2010.

The A&E department saw 80,029 patients during 2011/12. The trust has reported a 7% increase in their A&E attendance over the last year. During 2013/14 the department saw approximately 19,000 children. The service is available 24 hours per day every day of the year.

The department consists of three main areas, a minor injury treatment area, a majors area, which includes a dedicated treatment room for paediatric patients and a resuscitation area, which includes two bays for paediatric and neonatal emergencies. The department does not have a clinical decisions ward for patients who require observation for longer than four hours but are unlikely to need admission.

Summary of findings

We spoke with 21 members of staff from various roles including nursing, medical and support services. We spoke with 17 patients and four relatives who were waiting with their children. The feedback from people we spoke with was mixed. The majority of people we spoke with had positive experiences of using the service. Most felt that staff were caring, compassionate and treated patients with dignity and respect however four patients provided us with examples where they felt they were not treated or spoken to in a compassionate manner by staff.

The environment despite being purpose built was not fit for purpose. The department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'. The environment did not enable a safe environment to be able to monitor deteriorating patients or those with a mental health condition who required observation.

Lessons learned from incidents were not always taking place and where lessons were shared these were not embedded. The care provided to mental health patients within the department was suboptimal and placed patients at serious risk of harm. At the time of writing this report the trust were taking action to respond to concerns identified around mental health care.

There were substantial nurse vacancies. The department was reliant on agency and bank staff to maintain staffing levels. The trust acknowledged the numbers and skill mix of nurses was below the expected

Urgent and emergency services

level. There were five consultants in post and plans were in place to appoint a further three. This was below the expected minimum of 10 consultants recommended by The College for Emergency Medicine.

We observed that the service had established pathways in place to fast track patients with certain conditions. There were systems for staff to refer people for specialist mental health assessments where they were identified as having a mental health issue. The department was consistently meeting the 95% four hour target for adults and was a 92% for children and young people within the two months preceding our visit.

Staff were clear on the risks and areas in the A&E department that needed improvements but they did not feel engaged or empowered to make changes to improve the quality of service. Staff we spoke with felt that the service had improved in recent months. However the morale of staff in the department was very low.

Are urgent and emergency services safe?

The environment despite being purpose built was not fit for purpose. The department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'. We saw that the children's department was not dedicated only to children and young people. The environment did not enable staff to be able to monitor deteriorating patients or those with a mental health condition who required observation.

Lessons learned from incidents were not always taking place and where lessons were shared these were not embedded. We found that serious incident investigations were not always thorough.

The care provided to mental health patients within the department was suboptimal and placed patients at serious risk of harm. Staff were not following procedures to risk assess, care for or treat patients with a mental health condition. The mental health treatment room was not fit for purpose. At the time of writing this report the trust were taking action to respond to concerns identified around mental health care.

There were substantial nurse vacancies. The department was reliant on agency and bank staff to maintain staffing levels. The trust acknowledged the numbers and skill mix of nurses was below the expected level. There were five consultants in post and plans were in place to appoint a further three. This was below the expected minimum of 10 consultants recommended by The College for Emergency Medicine. The trust also acknowledged that the lack of permanent consultants and paediatric support was a risk to the service. In response to this the trust had plans to mitigate such risk by increasing the medical assessment on patient arrival; however this had not been implemented at the time of our inspection.

In the event of an aggressive and volatile situation there were panic alarms in place which meant that other staff would respond and support the incident when the alarms were triggered. We however found that not all staff were provided with conflict resolution training. This meant that staff were not fully supported around prevention and management of violence and aggression.

Urgent and emergency services

We found gaps in people's records where assessments should have been recorded. Patient's confidential records were not kept securely. This information included personal identifiable information and were accessible and in public view. Therefore confidential information was not secure.

Incidents

- There have been no recent never events reported that relate to this department.
- Staff knew when and how they should report incidents. There was an electronic system in place to support this process (Datix system).
- The department had reported a number of serious incidents in the months before our inspection but senior and junior staff we spoke with were either not aware or seemed uncertain of the incidents. For example we were aware that there had been an increase and trend in the number of misdiagnosis of fractures reported in the department which clinical staff were unaware of. We were concerned that learning from incidents could not take place if staff were unaware of the serious incidents that had occurred.
- In relation to recent incidents, we found that the service had not effectively implemented practice recommendations subsequent to investigations. One incident involved a poor handover of a patient to a ward area. Since this incident a handover tool had been put in place. However staff informed us that this was not used consistently and that during busy times health care support workers gave handovers to the ward opposed to nursing staff as is required. We were not assured that the service was embedding learning from incidents.
- Throughout the department staff told us that they did not receive feedback following serious incidents (SI), incidents or accidents. Staff were not aware of any reported incidents within the last six months. The majority were unable to give feedback from any lessons learnt within their department or others.
- The one example of a lesson learnt provided by a staff member related to an incident where a person with substance misuse issues had been discharged and then fallen outside A&E and hit their head which had led to physical health problems. A lesson learnt was that staff should accompany people outside the unit to transport to ensure their safety. Other staff we spoke with were unaware of this change in practice.
- There was no regular multidisciplinary meeting held in the department to discuss incidents or other governance concerns.
- We found that serious incident investigations (SI) undertaken by the trust were not always thorough. A SI investigation report examined identified that an absconsion assessment was not completed for a person who later absconded from the department. Staff had not assessed that the person was at risk of absconding despite records stating that the person tried to leave the room they were in twice. A risk assessment for suicide/ self-harm was not completed despite the person stating thoughts of self-harm. Nor were any needs assessed and documented that the person required staff observation. There was evidence that staff had not adhered to trust policies in relation to security, mental health and missing and absconding patients. The investigation report had not identified that there were any contributory factors to the incident by the trust or staff and there were no actions identified to be taken by the trust to reduce the risk of reoccurrence.
- A serious incident investigation report from October 2013, regarding an attempted suicide at the hospital identified that staff had not completed a psychosocial assessment for that person. Staff had not assessed the person as being at risk of self-harm despite a history of "Low mood" and depression. The police were escorting the person and there was no evidence that staff had assessed and documented that the person required A&E staff observation. The investigation report identified that a policy was required for staff to refer to when the police or others acted as escorts. There were not any identified contributory factors to the incident by the trust or staff and there were no other actions identified to be taken by the trust to reduce the risk of reoccurrence.
- We spoke with the commissioners regarding the quality of SI investigations and concerns were also shared regarding the quality of completion and they acknowledged that improvements were required.
- The trust collated information to be able to identify themes such as absconding and self-harm by people. We received conflicting information relating to the frequency of people absconding from A&E. Information from the trust stated there had been three absconsions by people during the first six months of 2014. Whereas

staff told us that it was more frequent occurrence, for example a staff member said, "It can always happen." Another staff member said people absconded, "Once every other day."

- We were aware of an incident through the local media that occurred during early 2014 where a young adult absconded from the department with serious injuries and had to be brought back by police. When asked, the trust were unaware of this event and informed us that they were unsure why it had not been reported. This meant that incidents occurring within the department are under reported.

Cleanliness, infection control and hygiene

- The environment was clean and tidy. Staff wore uniforms bare below the elbow and adhered to local infection control policy. There was sufficient hand cleansing facilities, gloves and aprons throughout the department.
- Staff washed their hands or used hand gel between patient contacts. Barrier nursing procedures were in place.

Environment and equipment

- Resuscitation equipment and trolleys were in place and checked daily.
- The major's area of the department had ten beds in the main area. There was an additional five beds (four beds in a bay and one bed in a side room next to the bay) near the ambulance entrance, some way down a corridor and through a set of double doors from the main major's area. The extra five beds had previously been part of the emergency assessment unit (EAU). We spoke with staff working in the area who told us they sometimes felt isolated from the main department. We asked that if staff pulled the emergency bell, where did the alarm sound? Staff told us they were not sure. When we pulled the emergency alarm it sounded in the EAU and did not sound in the A&E department. We could not be sure that in an emergency, patients would receive care and prompt attendance from staff from the correct department.
- We were also told that whilst the majority of patients were assessed in the main department before being transferred to the additional beds, on some occasions patients were admitted directly to those beds. We could not be sure that communication channels between the main major's area and the additional beds were safe. Staff on duty told us that the management were aware of the emergency bell concerns, however staff told us the beds had been open for approximately one year and no remedial action had been taken. After the inspection when we met with the CEO and Chief Nurse they assured us that the issue around the alarm sounding in EAU had been addressed.
- Staff told us that all patients in the ten bedded major's bay were cardiac monitored which could be seen at the nurse's station. Due to the layout of the unit it was not possible to see all the patients from the nurse's station. Staff told us that they did 'intentional rounding' at frequent intervals to mitigate the risk.
- The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. We saw that the children's areas were not dedicated only to children and young people. Staff had raised concerns about a lack of security during the day and at night specifically in the minor's areas because adults could access the children's waiting room and treatment rooms as there were no door locks. We saw that the corridor was used as a short cut to the X-ray department. There was also a lack of safe play facilities.
- The A&E security risk assessment had not been formally reviewed since November 2012. We saw the health & safety report from August 2014 which highlighted security risk assessments as a red risk and not compliant currently. Two reviewers at a recent 'Engage inspection' of A&E in June 2014 reported that they managed to walk around the whole department and nobody challenged their presence. This gave the team concerns about security and safety of vulnerable patients.
- Staff showed us a 'mental health' room where people whom staff had assessed as having mental health needs, such as self-harm, waited for specialist assessment by mental health professionals. The room was near the department's main entrance/exit and away from staff work stations. Despite electronic systems for restricting access we saw several occasions where entrance doors were open and not secure due to a delay in opening/closing. A staff member told us that exit/entrance doors had been identified by staff as a risk area for people to gain access but the member of staff was unclear what action was being taken to minimise the risk. Nursing staff told us there were no resources to wait with a person in the mental health room and that they

relied on relatives or other professionals such as the police to, "Keep an eye" on the person and ensure they were not at risk but they would periodically check on them.
- We saw alarms in the mental health room for staff or others to call for assistance in an emergency. At the time of our inspection the room had not been assessed within the last 12 months for ligature and self-harm risks. Following our visit a risk assessment of the room was completed assessing ligature points.
- Staff told us that there was not a procedure for asking people or checking their property where a person presented with self-harm, therefore people could have items with them which could place the patient, staff and others at risk of harm.
- Moving and handling equipment including a hoist, slide sheets and a PAT slide were readily available for use and staff were able to demonstrate knowledge in how to use them and show us where these were located. Staff were also clear on procedures in place for the admission or arrival of a bariatric patient.
- There were no clear lines of sight for staff to observe people in treatment areas of the A&E department. Some cubicles in the majors area were identified for people to be placed if staff assessed them as high risk of absconsion/self-harm offering staff greater observation of people.

Medicines

- Medicines were kept securely in locked cupboards behind doors with a keypad entry system.
- Four patient records did not have the allergy status completed. A patient reported on the NHS choices website that a relative was given the wrong medication which caused an allergic reaction (March 2014). Therefore there was a risk that people were not protected against the risk of receiving medication that was unsuitable for them.
- We checked a sample of medicines, including emergency medicines, these were in date and stored at the correct temperature. Fridge temperatures for medicines requiring refrigeration were checked daily to ensure medicines were stored correctly.
- We saw that controlled medicines were stored securely and checked correctly

Records

- We examined patient records on the day of our inspection. We saw that records were appropriately completed by the multidisciplinary team.
- Patient's care records confirmed that patients were assessed medically and that treatment plans were in place. However we found that not all routine assessments were being completed. Staff confirmed that due to being busy, basic assessments did not always get completed. This included skin integrity assessments. We found gaps in people's records where assessments should have been recorded.
- Patient's confidential records were not kept securely. In the minors area we found six trays on the front of the nurses' desk that contained personal care records of people that were either in the department or who had been discharged. This information included people's names, addresses, date of births, medical history and reason for attending the department. The records were accessible and in public view. Therefore confidential information was not secure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explain what they were going to do and asked for the patients consent before they proceeded.
- Staff spoken with were clear on the Children's & Adolescent Mental Health Support teams arrangements. They told us that safeguarding training included an over view of the mental capacity act and consent practices for children.
- Staff we spoke with referred to reporting safeguarding vulnerable adults and children concerns to the local authority and the trust safeguarding lead. We saw evidence of staff appropriately reporting concerns for a child. Leaflets for victims of domestic abuse were available for staff to give out.
- A serious incident investigation report identified that a safeguarding assessment had not been carried out when a person had talked of risk of harm to others and themselves. The report did not highlight that any actions should be taken following this. Five out of six people's notes we reviewed did not have completed safeguarding risk assessments. Therefore it was evident that staff were not consistently assessing the needs and learning from incidents.

- Whilst staff were completing crisis resolution home treatment (CRHT) referrals, the risk issue section was not routinely completed by staff although some information was given in the reason for referral.
- Staff reported receiving training on the Mental Capacity Act 2005 within safeguarding training. Staff explained their systems for assessing people's mental capacity to give consent regarding treatment. Staff also referenced assessing children as 'Gillick competent'.

Safeguarding

- We saw a current safeguarding policy for adults and children, which was accessible on the intranet. The policies were version controlled and the policies reflected national guidance.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse and how they would escalate such concerns appropriately. The trust had a safeguarding policy which was accessible to staff.
- We saw the training figures for the department. Within the last two years only 28% of A&E staff and 0% of emergency nurse practitioners staff had received the two yearly safeguarding training. This is significantly lower than what would be expected of staff working within the A&E department. The trust has informed us the change in figures was down to changes of training frequency within the county. We have been assured that measures to improve the training numbers are being implemented.
- 100% of paediatric staff had attended level 2 and 3 safeguarding. We noted that domestic abuse was touched on in induction, was outlined in Safeguarding Children and Adults Level 2 training and was covered in more detail in level 3 safeguarding children training.
- Staff were able to access child protection advice 24 hours a day from a paediatrician with child protection expertise. However we found that staff were not aware of a formal system in place to identify children and young people who attended frequently, who may be at risk.
- The levels of safeguarding supervision for clinical staff was low although minutes of a safeguarding meeting in April 2014 showed the trust are training additional supervisors to improve the levels of support.
- Staff shared concerns about the care provided to mental health patients in the department. One member of staff told us, "Mental health patients get a poor service here". Another told us that the service is, "Definitely a worry" and, "We do not have enough staff on duty to support mental health patients safely".
- We viewed the training information provided which showed that staff were not provided with training on mental health. Staff told us that they thought this was essential to their job given the increasing and high number of mental health patients seen in the department.

Mandatory training

- We saw that overall 71% of staff had attended mandatory training. This training included training in areas such as, infection prevention and control, moving and handling, induction and cardiovascular pulmonary resuscitation. Staff confirmed and training records showed almost 83% of staff in children's A&E had received mandatory training.
- To support staff in reducing instances of verbal abuse and aggression, conflict resolution training (CRT) days continued to be available through the training and development department. Uptake was lower than expected (21%). We also found that staff did not receive breakaway training. Therefore we are not assured that staff in the department are prepared to manage violent or aggressive situations because training had not been provided.

Management of deteriorating patients

- The department used the National Early Warning Score (NEWS) as a method of identifying deteriorating patients. We saw that scores were regularly updated and were recorded in a way that allowed staff in the department to quickly review them. Where patients were identified as at higher risk or their risk status changed we saw that they were appropriately reviewed.
- The paediatric resuscitation bay was a long distance from the children's treatment areas which could be problematic when moving a deteriorating child. The trust provided us with plans and assurances which demonstrated how they managed such children's cases. This included assurances that when a child is too sick to move from the treatment room, resuscitation or advanced care was provided then and there.

Urgent and emergency services

Assessing and responding to patient risk

- Staff told us that patients were triaged by nurses on arrival to the unit. However we were informed that it was common not to triage patients within the fifteen minute timeframe due to work pressures.
- Patients were routinely assessed using a recognised tool on admission for sepsis and stroke and were then placed on appropriate pathways.
- We were told that the department did not carry out rapid assessment and treatment (RAT). Staff told us there were, "A lot" of people presenting at A&E with mental health problems such as self-harm. It was evident that staff were not following trust policies to minimise risks to people. The trusts anti ligature policy 2014 identified the department as an area of 'high risk' and annual audits should take place. An up to date specific ligature audit was not available at the time of our inspection.
- The paediatric waiting area was out of view of the main desk within the paediatric area. This meant that staff were unable to visually monitor children in the waiting room for signs of deterioration. We asked two staff members about the monitoring of children in the waiting room when visual observation is not available. Both expressed concern about the waiting room and being unable to observe patients. One told us, "It is an accident waiting to happen." At the time of writing this report the service was planning to go to consultation to move the waiting room location to an area where patients could be observed.
- The 'Emergency Department environmental risk assessment' dated 04 December 2013 identified 'ligature' as a risk in the department. Individual ligature assessments should take place to reduce the risk of people self-harming on site. We examined the records of six people who had presented to A&E with mental health/ self-harm concern and found that five of the six had not been risk assessed. Therefore the risk of self-harm to people presenting to the department was not being assessed appropriately.
- In one person's records we saw an entry which said, 'Leads removed'. We clarified it meant that staff had assessed the risk of ligature from these items. However other ligature items such as clothing were not assessed.
- We looked at systems for staff supervision of people with mental health needs and found that there was a risk people were not adequately observed. Reference was made to '1:1 observation' during the transfer of self-harm patients in the 'Mental health patient treatment policy' however we found no requirement for this support in the 'Care of Patients with Dementia Policy' and 'Adult Patient Observation Policy'. These policies did not provide guidance to staff on how people with mental health needs should be observed.

Nursing staffing

- We found the staffing levels within the department were not sufficient. We spoke with senior management and they explained that recruitment and retention of staff had been a problem but was slowly improving. The department had a 14% vacancy rate for qualified staff at the time of our inspection. During the inspection staff made us aware that there would be further vacancies due to staff securing employment elsewhere. Senior management informed us that they were to shortly interview for new staff.
- We saw from rota's that numbers on the unit were broadly maintained with some reliance on bank and agency staff.
- The trust acknowledged the numbers and skill mix of nurses in the department were suboptimal and were working to upskill staff to improve the skill mix ratio. The department had recruited a number of senior nurses at the same time since the beginning of the year. Staff we spoke with told us they felt supported in their new roles by managers and colleagues. We were concerned about the impact on the skill mix of nursing staff because a number of senior staff had been recruited in short space of time.
- Nurses confirmed that the department used a high number of agency staff to fill shifts and shared concerns that permanent staff no longer want to do bank shifts because the trust had recently removed the specialist additional pay for A&E bank rates. One member of staff said, "They [senior management] would rather pay extortionate rates of pay to agency rather than give us specialist rates which are much less".
- Nursing staff we spoke with told us that the high turnover of staff was attributable to the multiple changes in leadership within the department in the past two years. However, one member of staff said, "Although we are short of staff, this is the best staffing has been for a long time here".
- The risk register detailed that the children's emergency department is insufficiently staffed - bank and agency staff were currently filling the gaps. Staff told us that due

to rising numbers of child attendances in the A&E department (approximately 19000 in the last year) there were insufficient children's nurses employed to provide an adequate service. This was evidenced by the delayed triage and assessment times.

- Adult trained nurses noted the skill mix was poor and they were not always confident in caring for sick children without adequate supervision by a paediatric trained nurse or doctor. A skill mix review was actioned in July 2014 to address concerns; the results were not available at time of inspection.
- Regular agency children's trained nurses were used at night and staff were confident in their competencies. We spoke with nurses who work autonomously to see and treat patients (usually called ENPs) these nurses confirmed they undergo an assessment of competencies in the anatomical, physiological and psychological differences of children.
- Patients we spoke with felt that there were shortages of staff within the department which impacted the service they received. Comments from patients included, "They do very well with the resources they have" and, "They are under pressure and by 4pm staff were on their last legs."

Medical staffing

- The department had five full time consultants covering the emergency department. The trust had implemented a series of measures to try to attract consultant staff with increased advertising, including a recent advert that had gone out for a paediatric A&E consultant.
- The expectation of The College for Emergency Medicine is that there should be a minimum of 10 but ideally 12 WTE consultants who must be available for at least 14 hours per day. We examined the staff rota and found that the consultant staff level was only established for eight, and at the time of our visit there were only 5 consultants in post with plans to recruit a further three.
- Two patients we spoke with raised concerns that they felt that there was not enough doctors on at the weekends when the department is busy. We established that consultants worked a 1 in 5 on call rota. Staff we spoke with told us that senior staff always attended the department when requested.
- There was a sufficient number of middle grade staff with at least one always on duty. Out of hours cover was provided by one middle grade doctor and two FY2 doctors.
- Medical staff we spoke with told us that there were a number of regular locum doctors used by the department and they felt well supported by them.
- There was 24 hour, seven day a week medical paediatric support for the children's emergency department. All staff working in A&E where children are present were trained in paediatric basic life support.
- Paediatric emergencies may also dictate the presence of an anaesthetist. We were advised that a call for assistance is made to an ODP and two anaesthetic middle grade doctors: one from the Burns unit (itself with a major paediatric workload) and one specifically on call (again, with a consultant) for paediatrics and obstetric emergencies. If consultant anaesthetist attendance is required, then one would be available to attend.

Major incident awareness and training

The trust's major incident plan was last ratified in 2012 and was subject to review on an ongoing basis as and when required. The major incident process had been tested in 2013 and a table top exercise had also been undertaken.

Are urgent and emergency services effective?

(for example, treatment is effective)

We observed that the service had established pathways in place to fast track patients with certain conditions. For example fractured neck of femur patients are meant to be fast tracked to the orthopaedic ward for treatment.

There were systems for staff to refer people for specialist mental health assessments where they were identified as having a mental health issue. There was an effective working relationship with the onsite Crisis Resolution and Home Treatment team. However A&E staff had not received specialist mental health training and therefore we were not assured that staff had the skills and knowledge to effectively assess people's needs and ensure appropriate care whilst waiting for specialist services.

Urgent and emergency services

Evidence-based care and treatment

- We randomly selected three policies which were easily accessible on the trust's intranet. All the policies were current; version controlled and referenced national guidance and recommendations.
- People with mental health needs either self-presented or were referred or brought to A&E by another agency such as ambulance staff or the police. People could also be diagnosed during admission if the condition was detected during the assessment/treatment by staff.
- Staff told us they used the Manchester screening tool in triage and did not use a specialist combined physical and mental health triage scale. A 'preliminary psychosocial screening tool pilot' checklist was used by staff, although not all staff were aware of this. This prompted staff to consider people's capacity, suicide or self-harm issues, presence of mental illness, behaviour disturbance, situational risk factors and any substance misuse. This gave staff prompts to refer to the Crisis Resolution Home treatment team (CRHT) or alcohol workers.
- Some staff referred to using information from the 'this me' booklet' developed for people with dementia going into hospital to further inform psycho social assessments.
- Staff had systems to request a specialist mental health assessment such as from the local mental health trust, Crisis Resolution and Home Treatment (CRHT) for adults, the Child and Adolescent Mental Health Services (CAMHS) and from older persons services once they assessed the person was medically fit for discharge and their physical health needs were met. We saw referral forms for CRHT. CRHT staff told us that additional risk assessments took place before people with mental health needs were admitted to a ward in the acute trust.
- The trust 'Mental Health Patient treatment policy' gave out of date guidance for staff to follow when working with people with mental health needs. For example referencing 'Approved Social Workers' (ASW) whereas the Mental Health Act 2007 replaced this term with 'Approved Mental Health Professionals' (AMHP's).
- We saw that staff were identifying details of substances used where people presented following an overdose .Staff told us that assessment would be undertaken to determine use of activated charcoal as early as possible where people had self-poisoned.
- Staff referred to giving verbal advice to people about the self-management of superficial injuries following self-harm. However notes we reviewed did not detail this.
- Care was not always being provided in line with standards for 'Children and Young People in Emergency Care Settings 2012'. The delayed triage times, poor security and monitoring practices in the waiting area were a cause for concern.
- We asked to see the department's national and local clinical audit programme. We saw evidence of local audits on the management of the sick child with actions detailed where gaps were highlighted.
- We saw that NICE guidance was followed in the department including assessment for and treatment for sepsis and stroke and local policies such as the antibiotic prescribing policy. Senior staff were aware of The College of Emergency Medicine guidelines.
- Prior to our inspection we were aware of a trend in incidents where misdiagnosis of fractured neck of femur within the department had occurred. At the time of our inspection there was a pathway in place for this including support from a specialist nurse. However when we asked the medical staff about any audits on misdiagnosis or themes from reoccurring incidents the medical staff were not aware that there had been an increase in misdiagnosis.

Pain relief

- We saw that when patients were triaged they were offered pain relief if it was required.
- We examined 10 sets of patient notes and found that patients were assessed for pain relief on admission. Records indicated that patients were given pain relief in a timely way.

Patient outcomes

- A number of audits were carried out in the department, including use of the sepsis assessment tool and sepsis care bundle.
- The key performance indicators for children April –July 2014 showed waiting delays with a mean average of 23 minutes for triage and 90 minutes for first assessment. These delays do not comply with standards for 'Children and Young People in Emergency Care Settings 2012'.
- Staff said a nationally recognised assessment tool for people with mental health issues was not used. We did not see that specific outcome measures were being sued in relation to people with mental health issues.

- We saw that specialist mental health assessment took place mostly within three hours and mental health staff documented the outcome in A&E notes. As required an urgent mental health assessment could take place. Assessments for intoxicated people took place after CRHT staff assessed them as being fit for interview.
- Mental health staff took the lead in contacting AMHPS for assessment under the Mental Health Act (MHA) 1983. Staff told us that the Accident and Emergency Quality Indicators had been breached for people staying in A&E beyond four hours, due to waiting for Section 12 approved doctors and AMHPS being available to visit to carry out assessments under the MHA 1983. Additionally times could be breached if people who were intoxicated and needed time to become 'fit for interview' by mental health or drug and alcohol workers. This is a nationally recognised concern that occurs within many hospital trusts.
- Staff from A&E were unable to tell us the arrangements for dealing with legal documents admitting people who were detained under the Mental Health Act 1983 (revised 2007). During our visit a person was admitted and it was unclear if they were detained under the Act or not. We saw A&E staff working with CRHT staff to clarify this. We later found that that clarification of their legal detention was made and the trust had employed a mental health nurse to support them during their stay until they could be admitted to the local psychiatric unit. We clarified that the person was placed under Section 137 MHA 1983 as they were deemed as receiving treatment for their physical health en route (being conveyed) to a psychiatric unit. Therefore staff are not up to date with the requirements of understanding detention and documentation arrangements to care for a detained person.
- Staff told us that people could not be detained under section 5(2) MHA1983 doctors holding powers in A&E as legal powers could only be used when a person was admitted to hospital. However the trust is registered for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 which does empower staff to make early decisions to admit and detain patients under the act where required. Therefore the trust may not be using its powers under the act to effectively protect patients.

Competent staff

- Staff shared concerns that there was no in house A&E training for nursing and support staff. One nurse said, "We need more basic A&E training like conflict resolution and mental health training".
- Senior nurses confirmed that they had achieved relevant post registration qualifications. This included Advanced Life Support and Emergency Care nursing awards. However care assistants and support workers were not supported to further develop their skills or undertake nurse training through the trust.
- As of June 2014, 43% of staff and 20% of paediatric A&E staff had received an appraisal. An appraisal is a personal development review of staff's performance objectives and a process for determining staff development needs. This is lower than expected and evidenced that improvements in staff support are required.
- As part of this supportive programme staff should also receive clinical supervision. We asked for the number of staff who had received supervision. Senior management told us staff did not have clinical supervision but undertook one to one meetings and provided leadership support where required.

Multidisciplinary working

- Staff told us there was poor access to mental health and psychiatric services, which are provided by another provider. An example was given where a patient with mental health concerns was admitted to the department without any acute concerns because the mental health trust were unable to take the patient due to a lack of beds. This is a nationally recognised issue however the trusts engagement with local services prior to our inspection was minimal. The senior leads within A&E informed us that they had made significant progress to improve the working relationships with the mental health trust.
- Two staff told us there were challenges with the paediatric service and liaison. One staff told us the service was developing but, "Kept hitting walls" for example with staff leaving and trying to provide a 24 hour service. They told us they valued having specialist staff available in the event of responding to emergencies and providing consultations.
- We saw evidence of effective multidisciplinary working in relation to certain conditions such as stroke which ensured patients got prompt specialist assessment and

treatment. The acute stroke team were based in the emergency department with a specialist nurse available 24 hours a day. Across all levels and professions, we observed good communication and observed sound rapport. One member of staff said, "I have been here for years because the team is excellent".

- Staff in the children's A&E spoke positively regarding the Emergency Nurse Practitioners (ENP) support and triage practices.
- Staff in the children's A&E were not aware of the process to involve a health visitor liaison or school nurse where necessary to support children discharged back into the community.

Seven-day services

- There was 24 hour, seven day medical paediatric support for the A&E Department. Within paediatrics, there was a consultant rota for both predictable and unpredictable on call arrangements. Each consultant was on call for a 'hot week' where each day they are on site until 20.00 hours and on call thereafter. There was one full shift middle grade doctor on site continuously and two SHO equivalent full shift paediatricians, available for emergencies.

Are urgent and emergency services caring?

We spoke with 17 patients and four relatives who were waiting with their children. The feedback from people we spoke with was mixed. The majority of people we spoke with had positive experiences of using the service. Most felt that staff were caring, compassionate and treated patients with dignity and respect however four patients provided us with examples where they felt they were not treated or spoken to in a compassionate manner by staff.

People we spoke with who were attending for the children's service were happy with the care received. Staff in all roles put significant effort into treating children with dignity and patients felt well-cared for as a result. Staff responded compassionately to children's pain, discomfort, and emotional distress in a timely and appropriate way. Emotional support for children through specialists such as play therapists was not apparent.

Compassionate care

- There were systems in place for staff to be able to identify the number of times a person had presented to the A&E department in the last year. There was a system for highlighting frequent attenders. We observed a special cases folder held in reception for staff to access, this was called the 'special circumstances file' and we noted that some trust and other agency documents referred to people with disrespectful terminology such as 'frequent flyers ' and 'hospital hoppers'.
- The NHS Friends and Family Test results for July 2014 showed that the A&E department scored 33%, for people who would recommend the hospital. This is a poor result and meant that patients in the majority were not satisfied with the care they received through A&E.
- In majors each person had their own room. We saw staff knocking on the door before entering and closing window blinds when giving care and treatment.
- People we spoke with provided us with positive examples of staff being caring in the department. Comments included, "Staff are polite and tell you what is going on" and "We are lucky to have this hospital". However other patients and relatives we spoke with felt that staff were not always caring. One patient told us, "Staff seem to have lost their love and could show more compassion." And another patient told us about their recent previous experience of the service, "I came in with a chipped elbow, doctor told me that they would not x-ray me to prove he was right. I went away feeling worse."
- Another patient who was previously treated for an overdose told us that when she asked if she could charge her mobile phone up that staff told her, "No" and "what do you expect you overdosed." The patient told us that they left the department after being spoken to that way. This meant that staff approach to care was not always caring and affected the outcomes of patient experience.

Patient understanding and involvement

- Whilst observing staff provide care to patients we saw that staff spoke and cared for patients in a kind and attentive manner. We observed good rapport built between the staff and patients.
- We saw that patients were given information about their condition and their plan of care. Records indicated that patients were given options in how best to manage their care.
- The majority of patients we spoke with told us that the care received was good. Positive comments included, "Staff on reception are very welcoming and calm" and "I

have had excellent treatment here." However four people reported poor involvement and experience of their care. Comments included "8 hours wait is ok if you know what is going to happen; they told me 'we've been saving lives' which is not ok" and "Staff give the impression that you are taking up their time, I don't feel like they care."

Emotional support

- We saw that there was an area within the department for bereaved relatives. This meant that families had privacy to grieve and their emotional needs were respected.
- Signage was displayed around the department containing information of support services available including chaplaincy, domestic abuse and cancer support.
- The emergency department was seeing more than 19,000 children per year, staff were not aware of the availability or plans for the provision of play specialists at peak times or access to a play specialist service which should be in place.
- Staff were not aware of any liaison with health visitors or school nurses to support children once back in the community.

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

Due to the design of the A&E department as well as high bed occupancy the patient flow in the department is poor at times. The paediatric department design has a negative impact on access and flow resulting in poor compliance with waiting times. Escalation plans and pathways were not fully implemented or embedded to support access and flow in the department such as the lack of Rapid Assessment and Treatment (RAT) process.

We did not see how the trust was reviewing and planning services to meet the needs of people with mental health needs considering national initiatives. Access to local mental health service was improving however the trust needs to review processes for provision of care to those with mental health needs.

The department had met the 95% four hour target on the majority of occasions in the two months preceding our inspection.

Service planning and delivery to meet the needs of local people

- There was an escalation policy. We observed how the escalation policy was to be used when the capacity within the department reached a peak. Feedback on department capacity was also fed back at bed meetings held throughout the day. This meant that the trust was aware of the risks around service capacity and demand throughout the day.
- There was not an identified 'Liaison Psychiatry Service' at the hospital however there were close links with the CRHT. There was no specific written operational policy or guidance that explains the referral process to local mental health services. Nor did we see reference to the Royal College of Psychiatrists 'Standards for Liaison Psychiatry Services'.
- The revised trust 'Mental Health Patient treatment policy' did not reference current guidance for emergency staff working with mental health needs in crisis such as The Mental Health Crisis Care Concordat or how this was being considered in the planning and delivery of services for people with mental health needs.
- There is a service level agreement in place between the local mental health trust and clinical commissioning groups (CCG) for the mental health liaison posts at the hospital.
- The paediatric waiting area was too small to meet current demand. Staff noted families sitting on the floor in main corridors when the unit was busy. One family told us that the, "Children's area at the weekend is always full".

Access and flow

- The department was consistently meeting the 95% four hour target for children and for adults in the two months prior to our inspection. This is a target set to ensure 95% of patients are seen within four hours of entering the A & E department. Staff told us that the four hour target was causing extreme pressures to staff. One member of staff told us that they felt, "Strangled" by the four hour target and the approach of the senior management team around delivering this target.
- The department was comparatively new. The configuration however meant that the resuscitation area was some distance down a corridor from the ambulance

arrival area. The major's area had one area of ten beds and another down a corridor of five beds. Staff told us that managing flow around the department could be a challenge particularly during busy times. Whilst the department is new the design does not support flow efficiency through the department.

- Staff told us that currently patient flow is poor at times due to the hospitals high bed occupancy causing a backlog in the A&E department.
- The nurse triage target for children is set nationally at 15 minutes. We examined the data for the trust which showed that over the last few months the triage time was 20 minutes to see the nurse and one hour to see a doctor. One assessment was recorded at 78 minutes due to no cubicles available for patients to be seen. Triage nurses we spoke with told us that they did not always see patients for triage within 15 minutes (as per College of Emergency Medicine guidelines) of their arrival in the department.
- The resuscitation area of the department had three adult beds, a fourth paediatric bed that was also used for adults when busy and a cot area for neonates. Staff told us it was common to step down patients from this area into the majors area of the department or step them up into the intensive care unit. They told us there were no formal criteria for this or process in place but it was based on clinical judgement. We asked if there was any audit carried out as to why and what types of patients were transferred but the senior staff who we spoke with told us that this was not done.
- There are only two major cubicles for children, which staff told us is not enough to cope with the demand and this did impact on paediatric care.
- We were told that monthly meetings were held with trust staff and local mental health trust staff. They identified that whilst CRHT staff were on site during the day until 9pm they had identified that late evenings were a busy time and there was a need for a twilight service such as 9pm to 3am which was being explored.
- In contrast with the CRHT service which was contactable 24 hours, staff told us that liaison with the CAMHS service to assess children's mental health needs was less effective. A staff member referred to "struggling" to engage this service. The service was available Monday - Friday 0900 – 1700 hours after then, staff contacted the out of hours the local authority emergency duty team and there could be a delay in responding. It was unclear what action had been taken by the trust to address this. Some staff told us that sometimes the needs of young people aged 16 to 18 years could be assessed by CAMHS or CRH staff. CRHT staff told us that if there was a delay then they would assess the needs and liaised with local CAMHS or children's services.
- Staff referred to contacting the trust's 'Elderly assessment team' to undertake socialist mental health assessment for older people. A staff member told us that there could be, "long waits" for assessment from the local mental health trust for older peoples assessment, despite the close proximity of the team.
- A staff member told us that the police regularly brought people to the A&E department under Section 136 Mental Health Act 1983 when they did not require physical health treatment instead of going to the designated place of safety. We understood that there was regular contact between the trust and police took place but no formalised meetings took place.
- Whilst it is a nationally recognised concern around patients with mental health concerns being brought to A&E, all acute hospitals are registered for the regulated activity of 'Assessment or medical treatment for persons detained under the Mental Health Act 1983' and improvements to this service are required to ensure the safety of patients with mental health concerns.

Meeting people's individual needs

- Translation services were available and posters in place to advise people, where English was not their first language.
- Staff knew they could contact switchboard to request the 'Big Word' service to provide interpreting services where required.
- Paediatric referrals are made from the Emergency Department to the middle grade paediatrician on shift. If the severity of the condition of the child necessitates the attendance of the consultant paediatrician then the referral is made directly.
- Staff we spoke with were not all aware who the named nurses to advise and support patients with learning difficulties or dementia were.
- There was a good use of signage around the department, though the signs were placed at a high level and out of view for some people, they did contain easy read signage for people with learning difficulties.

Urgent and emergency services

- Patients we spoke with felt that the signage into the A&E department from outside was poor. Comments included "It is not obvious where A&E is from the car park or how to get there" and "A&E is tucked away in the hospital and signage to get to it is poor."
- In the paediatric area relatives reported that there was a lack of stimulation for the children with no TV, books or play area etc.
- Three people we spoke with raised that the parking payment system caused them concern as it was pay and display. People informed us that they felt they always had to watch the time to avoid "Getting a parking ticket."
- Within the main A&E department waiting room three people raised to us that they felt it was poor that there was no supply of free drinking water. They told us "It is warm and we have been waiting for hours without any drinks, we can't leave to get one."

Learning from complaints and concerns

- We were concerned that staff appeared to be unaware of some of the serious incidents that had occurred in the department prior to our inspection and as such were unclear of any learning or changes in practice in response to these incidents.
- The trust monitored and responded to feedback on their service via the NHS choices website. We saw mostly positive feedback for treatment in A&E. We noted in July 2014 a person had commented, 'I'm a mental health sufferer and I've been treated disgusting' complaining about the mental health service provided and trust. The trust had invited them to contact the trust to discuss their concerns further.
- Staff we spoke with were not able to give examples of complaints and practice changes as staff engagement through team meetings, information sessions or training sessions were minimal. They did note a monthly all staff email for updates but that safety information was limited.

Are urgent and emergency services well-led?

Staff were clear on the risks and areas in the A&E department that needed improvements but they did not feel engaged or empowered to make changes to improve the quality of service. Staff we spoke with could not articulate the strategy of the hospital or long term plans for the A&E department but felt that the service had improved in recent months.

Whilst the trust supported the active recruitment campaign, staff told us that the pace to secure an appropriate skill mix was too slow. The majority of staff noted the current demands of the day to day operational management of the emergency department prevented opportunities for innovation and sustained improvement at this time.

Locally the department did not have a sufficient staff structure in place to ensure the service was well led. Whilst staff locally had no concerns regarding leadership, the leads covered large areas and required additional support to ensure that mentorship and leadership is consistently provided.

Vision and strategy for this service

- Staff we spoke with felt that there was no clear vision or strategy for the department due to the multiple changes in senior management over the past 12 months. The senior management team within the service were newly appointed and were working towards the development of a strategy and vision for the service but this had not been agreed at the time of our inspection.
- Staff we spoke with told us that the department had been improving in recent months and that they were on an upward trajectory.

Governance, risk management and quality measurement

- We had concerns about the governance and risk management systems within the department. Despite a number of serious incidents reported, staff were unaware or had little knowledge of the incidents or any steps taken to minimise risk of similar incidents occurring.
- Following serious incidents staff indicated there should be staff debriefs but were not aware of any taking place in their department. A staff member said, "If there has been a debrief, then I'm not aware."
- Staff shared concerns that they did not have unit meetings. Senior nurses had a team meeting one to two monthly. There was no evidence of dissemination of information from these meetings to junior staff.

- We examined a communication book in the staff room. The last entry in the book was dated 30 June 2014. There was minimal information in this book and it was not up to date. Not all staff were aware of this system.
- Staff were clear on the risks and areas in the department that needed improvements but they did not feel engaged or empowered to make changes to improve the quality of the service.
- There was consistency between what front line and senior staff said were the key challenges/problems facing the service. The risk register had some detail of staff worries but was not current with all concerns raised for example mental health care or the paediatric waiting room.
- The trust 'Mental Health Patients Treatment Policy' stated that annual audits were undertaken to review 'compliance with requirements to undertake appropriate risk assessments for patients, risk event reporting, communication and working partnership'. However this was not available. It was not evident how the trust was monitoring response times by the local mental health trust to referral requests and if delays were occurring.
- Most staff were unable to identify audits undertaken relating to working with people with mental health needs. A staff member told us the department would be taking part in The College of Emergency Medicine 2014/15 Clinical Audit: Mental health in the emergency department to review their practices and develop the service.

Leadership of service

- We were concerned that there had been a high turnover of leadership in the service. The nursing and clinical leadership of the department had recently changed. Staff told us that they felt this had impacted on the smooth running of the department.
- A new clinical led had recently started and had innovative ideas on service improvement. Medical leadership was visible within the department and junior staff told us that these colleagues were open and approachable.
- Staff raised concerns that there have been four to five nursing leads in the past two years. One nurse said, "Management is unstable here". Another member of staff did not know who the senior managers of the A&E department were and stated that when they had a serious personal problem recently, there was no senior person to talk to and get support from.
- The nurse leadership had also changed however the workload for the head nurse and lead nurse would not be sustainable long term. Both staff were clear and precise in their vision and passion for the service and the inspection team believed they could deliver change through positive leadership. However both are leads for other clinical services within the trust. Staff told us that they felt supported by the two new leads however their roles were stretched and they could not be in A&E as much as they were required. Therefore more support in the management structure is required to support the two nurse leads to deliver the required change.
- We found that the messages from the leadership team at senior and executive level were not always filtering to the department. Staff felt that some senior managers were visible but others were visible because of the bed availability and four hour target.

Culture within the service

- Staff we spoke with told us that they were encouraged to be open and transparent.
- Staff told us they felt valued by leaders in the service but not by the organisation. They said that they felt isolated from the rest of the hospital.
- We found that the staff in the department were committed to their roles and patient care however the morale in the department was very low.
- 'Clinical Tuesday' had been introduced whereby senior nurses worked clinically alongside more junior staff to provide support and role modelling to them. Whilst most staff welcomed this support we found that further work was required to improve this practice. One member of staff told us that senior nurses, "Bed managed opposed to pulling their sleeves up and helping us" and another said, "They come down and interfere, it's really frustrating".

Innovation, improvement and sustainability

- The majority of staff noted that the current demands of the day-to-day operational management of A&E prevented opportunities for innovation and sustained improvement at this time.

Urgent and emergency services

- Due to the current issues in A&E around capacity, flow and staffing concerns, we found that staff felt that the trust was reactive and did not feel empowered to change practices.
- Senior staff referred to the, “Engage” programme where members of the trust executive team visited different areas of the hospital. Additionally they told us there was a system of peer reviews whereby lead staff visited other departments and undertook peer reviews, developing action plans for any issues identified.
- We noted that there was an innovative development programme in place for middle grade and junior staff in the department. This supported their skill development to consultant level with greater levels of responsibility. Middle grade staff we spoke with were supportive of the development opportunities available to them and informed them that it would encourage them to stay employed by the trust.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Increase the number of permanent trained nurses, paediatric nurses and consultants within the A&E department.
- Embed skill mix assessments for nursing staff to ensure that skill mix is appropriate and ensures the safety of patients in A&E.
- Review the consultant rota to ensure that the minimum numbers of consultants are scheduled on the rota in line with The College of Emergency Medicine guidance.
- Review and improve the management and directorate structure which supports A&E leads to improve clinical excellence.
- Improve the care provision for mental health patients within A&E.
- Review the use of the rooms where mental health patients are placed for assessment.
- Ensure that the emergency alarm in the additional majors bays sounds in the correct department.
- Improve the environment in the A&E department, including paediatric A&E, waiting areas and the majors area, to ensure the safety and treatment of patients.
- Improve governance processes and embed an open culture of reporting, sharing and learning from incidents and complaints to improve the care and experience provided to patients.
- Increase attendance at safeguarding training for all staff and improve safeguarding awareness.
- Ensure that staff receive training to support patients with mental health needs.
- Improve the numbers of staff attending conflict resolution training and provide breakaway training.

Action the hospital SHOULD take to improve

- Take prompt action to ensure that the children's A&E department is in line with national guidance.
- Review working with the psychiatric liaison services, CAMHS and the mental health trust to improve the care provided to patients within the department.
- Improve multi-agency working with external agencies including the local ambulance trust and police force around mental health provision.
- Ensure that all staff work together effectively to enhance the experience of patients, ensuring effective communication at all levels.
- Ensure that risks are assessed and managed within the department.
- Hold meetings in the department to discuss incidents or other governance concerns to staff at all levels.
- Improve the completion of documentation, risk assessments and allergy status within A&E.
- Improve communications from the Board to the A&E department.
- Take prompt action to ensure that staff speak to and refer to patients in a dignified and compassionate way.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010. Care and welfare of service users. Proper steps had not been taken to ensure that service users with mental health conditions were protected against the risks of receiving care of treatment that was inappropriate or unsafe because of inadequate environment of the mental health rooms, treatment plans, lack of staff training and awareness around mental health concerns in the A&E department. The paediatric A&E did not meet the individual needs of children. The waiting room was unobserved and meant that deteriorating patient condition was not effectively monitored. The emergency call alarm in the four bedded majors bay sounded in a different department and did not alert A&E staff. Regulation 9 (1) (a), and (b)(i) and (b)(ii) and (b)(iii) and 9(2) of HSCA 2008 (Regulated Activities) Regulations 2010. Care and welfare of service users.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. The trust has not updated risk assessments, risk registers and policies and procedures relevant to patient care within the department. Therefore the trust has failed to regularly assess and monitor the quality of the services provided. The trust is inadequately analysing the quality of serious incident investigations that resulted in, or had the potential to result in, harm to a service user because the investigations missed key items of information and there was a lack of lessons learnt from incidents and embedding of lessons learned from incidents. Regulation 10(1)(a) and 10(2)(b) and (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing. There were an insufficient numbers of suitably qualified, skilled and experienced trained nurses and consultant doctors within the A&E Department.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Compliance actions

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010. Safety and suitability of premises.

Service users are not protected against the risks of unsafe or unsuitable premises because the A&E department is not of suitable design or layout. Mental health patients were treated and assessed in a room which was unsafe.

The paediatric A&E department does not comply with Children and young People in Emergency Care Settings 2012.

Regulation 15(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Safety and suitability of premises.