University Hospitals Plymouth NHS Trust

Derriford Hospital

Inspection report

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Date of inspection visit: 8 March 2021
Date of publication: 19/05/2021

Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Derriford Hospital

Not inspected

We carried out a short notice announced focused inspection of Derriford Hospital. We visited the trust on Monday 8 March 2021 between 12pm and 6pm and looked at the Urgent and Emergency Care (also known as emergency department - ED) and Diagnostic Imaging services. These services were inspected because we had received information giving us concerns about the safety and quality of the service. Our inspection had a short announcement (around 30 minutes) to enable staff to arrange to meet with us and for us to carry out our work safely and effectively.

At our last inspection we rated the trust overall as requires improvement, during this inspection we wanted to seek assurance that there was no ongoing risk to patients in Urgent and Emergency Care and Diagnostic Imaging. We did not inspect medical care (including older people care) or surgery, which were both requires improvement at the last inspection, because we are monitoring the progress of improvements to these services and will re-inspect them as appropriate.

As this was a focused inspection to look at specific concerns, we only inspected parts of the key questions of safe, effective, responsive and well-led. Due to the narrow focus of this inspection, we did not change all ratings and previous ratings remain. However, there were changes to ratings for Urgent and Emergency Care in safe and well-led. The previous rating for Derriford Hospital of requires improvement remains.

See the Urgent and Emergency Care and Diagnostic Imaging sections for what we found.

During our inspection of the Urgent and Emergency Care service we identified a breach of regulation 12; safe care and treatment. After the inspection we told the trust it must make improvements. We took action under our enforcement powers by issuing the provider a Warning Notice served under Section 29A of the Health and Social Care Act 2008. We also identified additional breaches of regulation 12; safe care and treatment, and we issued the provider a Requirement Notice. Where we have identified a breach of a regulation and we take action under our enforcement powers, such as issuing a Warning Notice, the rating linked to the area of the breach will normally be 'inadequate'.

How we carried out the inspection

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

Diagnostic imaging

Inspected but not rated

Diagnostic Imaging

University Hospitals Plymouth NHS Trust Imaging service line provides diagnostic imaging services to a wide range of patients across Devon and Cornwall. They provide services at Derriford Hospital, the Radiology Academy, South Hams Hospital, Tavistock, Launceston, Liskeard, The Cumberland Centre and Mount Gould Local Care Centre.

They provide a comprehensive range of diagnostic imaging including:

• Plain film x-ray: Plain film X-rays are two-dimensional pictures of the inside of the body.

• Computerised tomography (CT): a technique using cross-sectional images using x-ray.

• Magnetic resonance imaging (MRI): a medical imaging technique to form pictures of the anatomy and physiological processes of the body.

• Ultrasound: sound or vibration using an ultrasonic frequency used in medical imaging.

• Fluoroscopy: medical imaging showing a continuous x-ray image on a monitor.

• Nuclear medicine: (NM) uses small amounts of radioactive material to diagnose, determine the severity of or treat a variety of diseases, including many types of cancer and heart disease.

Nuclear medicine is the largest such department in the South West, with tertiary referrals from across the Peninsula. It has four gamma cameras and a Medicines and Healthcare Products Regulatory Agency (MHRA) - licensed radio pharmacy and dedicated medical and physics support. The full range of diagnostic procedures (imaging and non-imaging) is offered, together with thyroid clinics. There is shared access to a single treatment room on Brent ward for an increasing range of radioisotope treatments.

The Imaging Department at Derriford Hospital consists of 19 x-ray rooms, 13 ultrasound rooms, six MRI scanners and six CT scanners. The Imaging service line carried out approximately 360,000 exams in the year prior to the COVID-19 pandemic.

Activity:

In the last 12 months prior to our inspection (from March 2020 to March 2021), there were 274,811 diagnostic imaging procedures carried out across all services within the trust of which 4604 were for paediatric patients (Acute Paediatrics and Community Paediatrics). The three modalities (methods of imaging) who performed the most diagnostic procedures were:

• Radiology: 134,919 plain film x-rays

• CT: 48,617 CT scans

• MRI: 23,631 MRI scans

Diagnostic imaging

Overall Summary:

We carried out a focused inspection of Derriford Hospital diagnostic imaging service on 8 March 2021. During this focused inspection we concentrated on specific parts of the key lines of enquiry within the safe, effective and well led domains. We did not inspect responsive or caring on this visit, but we would have reported on them if we found areas of concern.

For this inspection we considered new processes which had been recently implemented, followed up actions from a previous incident and reviewed governance of the service.

Due to the narrow focus of this inspection, we did not change the rating of the service from our last inspection in 2019. Our overall rating of the diagnostic imaging service therefore stayed the same as requires improvement.

We found:

- Staff identified, responded to and removed or minimised risks to patients. Staff followed emergency protocols that ensured patients went down the correct imaging pathway to meet their needs. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff monitored the effectiveness of care and used the findings to make improvements and achieved good outcomes for patients. Action had been taken to manage patient waiting lists across the diagnostic imaging service.
- Leaders now had the skills and abilities to run the service and understood and managed the priorities and issues the service faced. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders within the service understood and managed the priorities and issues the service faced. Leaders were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. There was clear oversight by service leaders to ensure successful implementation of the vision and strategy.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff felt included and their views were used to change the service. Development of staff was well managed. Staff felt that service leaders were pro-active with their support. Staff were positive about their work, their managers, and the support they received.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders and teams used systems to manage risk and performance effectively.
- Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. Service leaders implemented and monitored action plans to address each identified risk. The service had plans to cope with unexpected events.

Diagnostic imaging

- The service collected reliable data and analysed it. Information was easily available for staff to have oversight of their own department. 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. Staff felt involved in the changes in the service provided.

However:

- The service faced challenges with staff sickness and vacancies which posed a risk to provide enough staff to keep up with demand to care for patients and keep them safe. Actions had been taken to minimise the risk.
- Not all staff training records were up to date or logged correctly onto the trusts electronic system. This made it difficult for service leaders to check that those staff had completed necessary training.

Areas for Improvement

We found two things the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent beaching a legal requirement, or to improve service quality.

For more information, see the 'Areas for improvement' section of this report.

How we carried out the inspection

We visited the ultrasound and trauma CT (computerised tomography) scan units, the outpatient scanners and CT West. We spoke with two nursing staff, eight radiographers and the radiology leads. We also spoke with service improvement leads and the service lead and clinical lead for the departments. We looked at eight patient records. We also reviewed trust policies and procedures, staff training records and competency assessments, performance dashboards, meeting minutes and quality governance records.

Is the service safe?

Inspected but not rated

Assessing and responding to risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Staff followed safe systems of work so that risks to patient safety were identified, responded to and removed or minimised. The service had received concerns via external agencies about how protocols were developed and introduced within the diagnostic imaging department, specifically computerised tomography (CT), and whether they could impact on patient safety. The concerns about risks included an increase in patients' exposure to radiation, or potential risk to unborn babies if a patient's pregnancy status was unknown. There had been no recorded incidents of patients coming to harm due to this protocol. As a result of the feedback, the protocol was reviewed by a multidisciplinary team (MDT) within the service and amendments made. Staff confirmed the updated protocol had provided clarity, with clear flow charts to follow to identify the patient required pathways and pregnancy status. This ensured the risk of harm to patients was minimised.

Diagnostic imaging

Staff followed emergency protocols that ensured patients went down the correct imaging pathway to meet their needs. When patients arrived at the emergency department at the hospital, they were assessed by a trauma lead. This was a staff member with the skills and experience to make critical decisions about people's treatment. Their presentation assessment would identify if the patient required the stroke, trauma or surgery pathways, and on that decision the appropriate protocol for scanning was undertaken. The trauma scanner was located very near to the assessment area to minimise travel time in an emergency.

Updated radiologist protocols were available to guide staff when dealing with trauma patients, to ensure a safe and consistent practice. For example, a CT trauma protocol was available to speed up response times for patients to be scanned, so that staff could assess the severity of the patient's injuries and plan appropriate emergency treatment. The protocol had been created by collaboration with the leaders from computed tomography (CT), trauma and the emergency department.

Staffing

The service was under pressure to ensure that there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and were available to provide the right care. Leaders within the service had recognised their ability to respond to increased demand for diagnostic imaging, as the country came out of the COVID-19 pandemic, was at risk.

Service leaders had taken action to mitigate the risks posed by potential staff shortages caused by vacancies and sickness. They had identified that shortage of some staff, such as care assistants in the ultrasound department was key to continued improvement in diagnostics and productivity. While permanent recruitment was under review, the staffing shortages were being managed by block booking care assistant support through contingent workforce arrangements. This minimised the impact to the number of patients that could be scanned and helped to reduced patient waiting times. Other initiatives such as the use of an additional CT scanner based on the site of a different organisation, and an additional MRI scanner at the hospital, both of which came with their own staff, had enabled the service leaders to focus on how they effectively deploy their existing staff within the department.

Recruitment was ongoing and had included successful recruitment of oversees candidates. In September 2021, a new apprenticeship process is planned to be introduced to add an additional recruitment stream into the diagnostic imaging service.

Staff confirmed they always had the correct number of qualified staff to carry out procedures. For example, never less than two people at the correct skill level operating a scanner. Staff meetings were held daily as a 'huddle' to review the workload and ensure there was enough staff cover. An increase in demand meant staff would take up extra shifts to ensure suitable cover was available.

The service had identified issues in retaining students who had not applied for jobs at the end of their third-year training. A review of training records carried out by service leaders showed that a significant number of new starters in one training group did not stay within the trust on completion of their training. The reasons recorded were that they felt they were not involved and not being taught. The issues around this had been addressed and the current years cohort of trainee staff felt more engaged and happier. A plan had been created to utilise the trusts satellite sites more often for newly training staff as this would allow more one to one support in a less busy environment.

Records

Diagnostic imaging

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

Staff maintained patient records so that they were clear, up to date, stored securely and easily available to those who provided care. The eight patient records reviewed during the inspection contained all the necessary information to enable staff to identify the individual and understand what procedure they were visiting the hospital for. Records clearly showed Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) practitioner and operator details, along with justifications for the examinations by radiologists. Where applicable, all patients had copies of a pregnancy questionnaire scanned in, so supporting staff knew what procedures would be safe to carry out.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff recorded incidents and accidents on the trusts central electronic recording system which were well managed. Where needed, incidents were notified to outside agencies, such as for IR(ME)R notifiable incidents. A review of accident and incident data showed that staff followed the correct reporting process and the trust had submitted notifications to external agencies, such as CQC, as required.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were able to explain the process by which accidents and incidents were recorded, and what the duty of candour was and their responsibilities under it. The duty of candour is a statutory (legal) duty to be open and honest with patients (or service users), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. When incidents had taken place that required staff to consider their responsibility under the duty of candour, staff recorded when and how they had fulfilled this with the patient or their relatives.

Leaders within the diagnostic imaging Service Line carried out thorough independent incident investigations to identify the root cause of incidents. The relevant team then took action to address any issues identified and put in measures to prevent reoccurrence. Staff were able to learn from accidents and incidents. Meetings that covered all the different services within the diagnostic imaging department were used as opportunities for learning, feedback and discussion. Additionally, data was presented at the quality assurance group and modality lead meeting. This enabled trends and patterns to be identified, which could indicate further action was required, to look at how prevention could be implemented.

Serious incidents, such as delayed diagnosis that may have impacted patient health had been investigated. The root cause that caused the delay had been identified and action had then been taken to minimise the risk of the same thing happening again. Staff also reviewed patient records to ensure other patients had not been impacted by the same error. Staff had identified three unreported scans as part of this process. We were assured by our review of eight patient records during the inspection, that the actions taken by staff had reduced any ongoing risk to patients.

Managers ensured that actions from patient safety alerts were implemented and monitored. NHS England and NHS Improvement send out patient safety alerts to healthcare providers. These alerts require action to be taken by healthcare providers to reduce the risk of death or disability. Alerts such as these were included in team meetings within the diagnostic imaging department, to discuss the learning and if any changes to practice were needed as a result. Staff were knowledgeable about external reports, such as the Richards Report published in October 2020, and how the findings about reform within the diagnostic imaging field across the UK could impact the work they do. Professor Sir

Diagnostic imaging

Mike Richards was commissioned to undertake a review of NHS diagnostics capacity (NHS Long Term Plan). The independent report, Diagnostics: Recovery and Renewal, recommends the need for a new diagnostics model, where more facilities are created in free standing locations away from main hospital sites, including on the high street and in retail locations, providing quicker and easier access to a range of tests on the same day, supporting earlier diagnosis, greater convenience to patients and the drive to reduce health inequalities. (Source: NHS England website)

Is the service effective?

Inspected but not rated

Competent staff

Not all staff training records were up to date or logged correctly onto the system. This made it difficult for service leaders to check staff had completed necessary training.

Clinical leads within the department had identified issues with accessing/finding training records for plain film radiographers. This was because radiographers kept their own training records and held the responsibility to store them centrally when completed and signed off. They had not consistently done this. A departmental plan for all updates to be completed on the training system was due to be finalised by the beginning of April 2021.

Managers appraised staff work performance and held supervision meetings with them to provide support and development. Staff at all levels confirmed they were able to ask for advice from more experienced colleagues, for example they could discuss scanning protocols. They were given help in response to their questions, and decisions and rationale were explained to aid their understanding and learning. One staff member said, “I’m supported to develop new ideas, to extend my role and help with service improvements.”

The service provided care and followed procedures based on national guidance and evidence-based practice. Staff completed mandatory training in accordance to best practice guidance. For example, changes in infection prevention and control procedures issued by government agencies in response to the COVID-19 pandemic had been well implemented.

Managers appraised staff’s work performance and held supervision meetings with them to provide support and development. New staff had to complete a training programme based around the specific role they were going to do. Within the CT department, new staff began as supernumerary (which meant they were present in excess of the normal number of staff) and as their skills developed, they became the second person working on procedures. These staff were then able to gain experience, while minimising the risk to patients by shadowing more experienced staff and staggering shifts. They were never placed on night shifts on their own until their competency had been assured and they felt confident to do so. Staff training had a timescale for completion to ensure skills were acquired in a timely way. New staff were expected to complete their training within six months, with an appraisal (a formal assessment, typically in an interview, of the performance of an employee over a period) taking place after the first three months to review their progress.

Patient Outcomes

Diagnostic imaging

Staff monitored the effectiveness of care and used the findings to make improvements and achieved good outcomes for patients. Action had been taken to manage patient waiting lists across the diagnostic imaging service.

The risks to patients due to delays due to the COVID-19 pandemic had been risk assessed by the service. Due to COVID-19, many aspects of non-urgent care had been paused during 2020. This meant that waiting lists for many NHS services had increased, increasing the risk of people not getting access to treatment when they needed it. The diagnostic imaging service had assessed the risk of harm to patients awaiting scans throughout this time, taken prioritised action and had maintained as much activity as possible during the pandemic.

The impact of COVID-19 was still being felt, with each appointment taking longer. This was due to the stringent cleaning needed between each patient, which continued to have an impact on waiting lists. The diagnostic imaging teams held two-weekly review meetings with the performance team to review the waiting list situation, identify and tackle any sticking points, and then feed the results into improvement projects. This ensured waiting lists were constantly monitored and patients most at risk were prioritised for treatment.

Action had been taken to manage waiting lists across the diagnostic imaging service. Areas such as the magnetic resonance imaging (MRI) were able to decrease the waiting list numbers by taking advantage of the reduced demand for the service over the summer of 2020 and increased the number of scans completed. This was done by outsourcing some work, and some staff working from home to review and report on scans. The number of patients waiting six weeks or more for a diagnostic test had reduced from a peak of 3559 in May 2020 (46.4% of the waiting list) to 1257 (17.3% of the waiting list) at the end of August 2020. Due to increased patient demand, the number of patients waiting for over six weeks for a diagnostic test at the end of December 2020 had increased to 1610 (19.8% of the total waiting list).

The waiting times for patients on cancer pathways had shown little change, despite the pressures caused by the pandemic. In December 2020, 80% of suspected cancer patients awaiting a CT scan, were scanned within seven days, with 78% of patients being scanned by the MRI department. Ultrasound scanning was a third lower at 52% being scanned in seven days, however over two thirds were scanned within 10 days.

Is the service well-led?

Inspected but not rated

We did not rate well led at this time and the previous rating of requires improvement remains.

Leadership

Leaders now had the skills and abilities to run the service and understood and managed the priorities and issues the service faced. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders were visible and approachable in the service for staff.

Leadership vacancies had been filled which had improved the stability of the leadership team. There had been a lack of consistent leadership within the service which had now been addressed by the trust. Leadership across the diagnostic

imaging service had been inconsistent until the end of 2020, with vacant posts or posts being filled, then vacated. Staff confirmed that this situation had now stabilised within the service, with permanent leaders in post. The stable management structure had improved communication across the service and staff told us morale continued to improve as a result.

The leaders within the service were aware of the challenges with increasing patient waiting lists and had implemented systems to try to address them. Initiatives such as a 'production wall' had been implemented. This was where teams came together daily to talk about challenges they faced, and the support they needed. This had developed the team as it had brought together everyone within the department, from consultants and radiographers to porters. Some of the challenges discussed included the need to increase the workforce, as detailed earlier in this report. Other discussions included COVID-19 recovery and how to ensure people most at risk were seen as quickly as possible.

Leaders within the service understood and managed the priorities and issues the service faced. For example, feedback from a student cohort had been raised. As a result, improvements had been implemented. These included better support for students, introduction of a co-ordinator, better engagement and contact with students, and identifying student placement slots so they could gain experience, while not overwhelming existing workforce staff. Recent feedback had shown an improvement in the student experience as a result of the changes made.

Service leaders supported staff to develop their skills and take on more senior roles. Staff told us that the service leaders are visible as they walked around the department, talked to them, and enabled staff to ask questions or raise concerns if needed.

Leaders had ongoing plans to continue to build on improving communication and engagement with their staff and to continue to address the issues that had been identified at our last inspection.

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. There was clear oversight by service leaders to ensure successful implementation of the vision and strategy.

The diagnostic imaging teams had a clear vision and strategy for continuous improvement of their department. The services current vision included addressing the back log of patients caused by COVID-19, the development of their teams, and to work with the Clinical Commissioning Group (CCG) to develop an imaging network across Devon and Cornwall. The role of this network would be to ensure standardisation of imaging practice across the counties. This had been formalised in the diagnostic imaging vision statement: 'To provide a safe, sustainable diagnostic service to meet the stated clinical requirements of the trust and CCG, in line with national guidelines and best clinical practice. To work towards CQC excellence and Quality Standard for Imaging accreditation. To create a supportive, inclusive, and diverse culture of learning and improvement for our staff.'

Clear responsibilities had been defined that identified leaders, and how progress on improvement projects would be monitored for example, reporting to quality assurance groups and to the trust board. The formal strategy statement for diagnostic imaging was under development at the time of our inspection, as part of the ongoing improvement process.

Culture

Diagnostic imaging

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff felt included and their views were used to change the service. Development of staff was well managed. Staff were positive about their work, their managers, and the support they received.

Staff felt involved in process changes and told us they were able to raise concerns when the need arose. One staff member said, “New procedures are open for discussion at team meetings.” Staff were informed of updates to procedures via email, and at team meetings.

Development of staff was well managed. Initiatives such as putting short, medium, and long-term plans/visions as part of staff development had been implemented. Additional development had been supported by the trust initiative ‘managers passport,’ that gave guidance and training to those that wanted to move into a management role.

Staff felt that service leaders were pro-active with their support. Team meetings enabled them to raise issues, and there were also monthly meetings to review audits, policies and procedures that they could be involved in. Their learning and development had been maintained during COVID-19, and changes in the department structure have been positive and modernised the service.

Staff were positive about their work, their managers, and the support they received. One staff member said, “This is the best place I ever worked at.” Another said, “We have a great team, we are very close knit.” Staff told us they felt proud to be part of a specialist service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders and teams used systems to manage risk and performance effectively.

Service leaders used effective governance processes to review, analyse and report on performance within the diagnostic imaging Service Line. Detailed reports were produced, such as the ‘service line report to care group’ paper, that provided the Clinical Support Services Care Group management team with a rounded overview of the service provided to patients. This report also gave assurance that governance systems were effective and achieving acceptable compliance with the CQC’s five domains of care (Safe, Effective, Caring, Responsive and Well Led). The report also included a self-assessment against the four ratings that CQC use (Outstanding, Good, Requires Improvement and Inadequate).

Leaders within the department were able to identify through governance systems, such as the service line report, where internal governance systems were not being effectively used by staff. For example, where six out of 38 clinical audits had not reported findings. Action had been taken to rectify these omissions.

Staff were encouraged to be part of the governance process and monitor their own service. Staff had several opportunities to be involved in governance processes and drive improvement. There were Clinical Trial Unit (CTU) group meetings, but not all staff attended as capacity to attend limited their access. Additionally, service improvement meetings and Continuing Medical Education (CME) meetings for education and staff development took place, giving further opportunities for staff to engage with service leaders and changes to the department.

Leaders and teams used systems to manage risk and performance effectively. Staff used a series of clinical and internal audits to monitor the service provided to patients. Staff within the diagnostic imaging department used computerised dashboards to monitor a range of performance data. Areas covered included staffing levels, sickness levels, complaints, incidents and mandatory training compliance. From our analysis of this data as part of our inspection, the service had

been effective at reviewing incidents and had taken appropriate action in response. Staff had also effectively identified trends in the data, for example an increase in extravasation (the unintentional leakage of vesicant fluids or medications from the vein into the surrounding tissue). As a result, the data around these incidents was being collated and analysed to see if any improvements could be made to processes.

Managing risks, issues and performance

Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. Service leaders implemented and monitored action plans to address each identified risk. The service had plans to cope with unexpected events.

Risks were identified and monitored to ensure they remained visible and a priority for action. Department leaders maintained a risk register to make sure these were recorded, and that systems and processes ensured any impact to patients and staff were mitigated. Staff had a clear understanding of the criteria that needed to be met for an item to be placed on this register, and how to get an item added. This could be by a member of staff raising a concern, through quality assurance results of equipment such as an increase in repairs or servicing, or by incidents taking place within the department.

Service leaders implemented and monitored action plans to address each identified risk. Three serious risks had been identified within the service risk register, and plans had been developed to address each concern. Items on the risk register were highlighted at monthly meetings where the actions taken would be reviewed and the risk level could then be upgraded or downgraded in response. The information was also triangulated at care group level. These risks were also shared with leaders within the trust by way of the quality assurance group report, so senior executives and board members had oversight.

Contingency plans were available to manage and reduce the impact of unexpected events. Service leaders were involved in regular meetings with the trust financial department and explained how the trust had invested in new scanning machinery and had a replacement equipment programme to minimise the impact of machines breaking down or becoming outdated. Leaders reported they felt supported from a financial standpoint with regards to recruiting new staff.

Managing information

The service collected reliable data and analysed it. Information was easily available for staff to have oversight of their own department. 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. Staff felt involved in the changes in the service provided.

Staff could find the data they needed which was in easily accessible formats. This enabled them to understand performance, make decisions and improvements. Information was gathered and used to monitor the running of the imaging services. The governance lead within the diagnostic imaging Service Line had good oversight of how the service was running. Each month a written list was produced that listed key areas of oversight. The staff within the different modalities in diagnostic imaging were then able to access this information for themselves. The information was readily available in one place and available to all staff. This was used to monitor changes in the service, and make sure these changes were effective.

Diagnostic imaging

Work was ongoing in updating and improving information dashboards to make them individual for each modality within diagnostic imaging. This would improve the system because each department lead could then take responsibility for tracking performance of their own team, rather than having all the departments information combined, which then needed to be separated out for each department.

Information was easily available for staff to have oversight of their own department. In addition to electronic systems, staff information about quality improvement updates were displayed on a staff area wall. One was provided for each department. The information available to staff included performance data, updates on programmes, feedback from staff and what had been done in response. From the information on display, we could see that all levels of staff within the department were involved in decisions and improvement projects.

A process of ongoing improvement was evident in this service and staff were committed to continually learning and improving services for patients. The diagnostic imaging service had been through several continuous improvement changes since our last inspection in August 2019, and this process was still ongoing at the inspection in March 2021. Some permanent leadership roles had only recently been filled, and these staff held key positions to ensure continuous improvement was embedded and sustained within the department. The new leadership was in its infancy and time was now needed to develop and embed the positive changes being implemented. One leader explained that the improvement process had become more effective now the structures for team reporting and responsibilities were available and with the filling of deputy posts. The teams were also now all pulling in the same direction and focussed on providing the best service they could to patients.

Staff understood the improvement systems within diagnostic imaging and how they could feed into the process. Team meetings, or 'huddles' took place each day, and any ideas for improvement would then be fed into the weekly improvement board. An improvement newsletter was also sent out to staff every two weeks, which included a snapshot of events, large improvements and their progress. There was also a staff 'shout out' which was a celebration of improvements that had been implemented and their impact to the service.

With stable leadership, and a staff team that felt involved, improvement within the service was evident. Staff told us that by seeing small improvements they were encouraged to be involved with bigger changes. The improvements were now department and team owned, with ideas coming from within the service itself.

Areas for improvement

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.

The diagnostic imaging service should:

- Continue with recruitment processes to ensure there are enough staff to meet the ongoing and increased demand for the service.
- Monitor and improve the systems used to record staff training to enable a clear and accurate oversight of staff skills.

Urgent and emergency services

Requires Improvement 

Emergency Department

The emergency department at Derriford Hospital is the largest in the South West of England and operates 24 hours-a day, seven days-a-week. It is a designated major trauma centre for adults, providing care for the most severely injured trauma patients from across the South West. Additionally, the department provides trauma unit facilities for children, meaning it can receive and stabilise children prior to them being transferred to an appropriate paediatric major trauma centre.

During the latter part of 2020 the trust introduced senior triage assessment rapid treatment (START) to the emergency department, so there is one entry point to the department for ambulances and those who make their own way. The reception has a seated waiting area and a glass-fronted reception desk with a lowered counter for wheelchair users. A separate seated waiting area exists for patients requiring assessment and treatment of minor illness or injury.

The emergency department has; seven resuscitation bays, 16 cubicles for major illness and injury, four cubicles for minor illness and injuries, four paediatric cubicles and a paediatric waiting room in a dedicated paediatric department, a 10-bedded clinical decision unit, and seating for eight patients in the clinical decision unit lounge (this has reduced from 10 to allow for social distancing). Within the resuscitation area there is an overhead x-ray facility.

The hospital also benefits from an acute assessment unit which houses primary care streaming and frailty care pathways. These are designed to deliver timely care in collaboration with primary care partners and avoid hospital admission where possible.

From November 2019 to October 2020 the total emergency attendances were 96,479 which was down 37% from the previous year. Children attending the emergency department represented 14,927 in that same time, down 52% from the previous year. This fall in attendances is due to the COVID-19 pandemic where nationally there was a fall in patient numbers attending emergency departments, in particular during the months of April, May and June 2020. In February 2021 there was a total of 8,622 emergency department attendances (6,358 were type 1 attendances).

The trust is part of the rapid care assessment pilot trialling the four new standards set out in the NHS's review of clinical standards, which includes identifying life-threatening conditions faster, reducing emergency time for critically ill patients, and the main waiting time for all patients.

Overall summary

We carried out a focused inspection of Derriford Hospital urgent and emergency care service for adults and children also known as emergency department (ED), on 8 March 2021 as part of our winter pressures programme. As this was a focused inspection, we only inspected parts of three of our key questions: safe, responsive and well led. We did not inspect effective or caring on this visit, but we would have reported on them if we found areas of concern. At our previous inspection in 2018, caring was rated as Good. Effective was rated as Requires Improvement.

For this inspection we considered information and data and the concerns this raised over the ability of the department to respond to patient need, and the overall performance of the department, and the wider trust in relation to responsive care and waiting times for patients. We were also concerned with delayed and lengthy turnaround times for ambulance crews.

Urgent and emergency services

Our inspection had a short announcement (around 30 minutes) to enable staff to arrange to meet with us and for us to carry out our work safely and effectively.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the ratings for safe and well-led went down. We rated safe as inadequate and well-led as requires improvement. Please refer to the 'areas of improvement' section for more details.

Our overall rating of the urgent and emergency care service stayed the same as requires improvement.

During our inspection we found:

- We were not assured patients were safe while they waited in crowded areas and we identified lapses in practice around infection prevention and control.
- Given the current pandemic, and limited footprint of the department, efforts had been made to protect patients and staff, but the design and use of some parts of the premises did not always keep patients safe.
- We were not assured there was adequate oversight and responsibility of the patients who were waiting to be seen and patients were not being seen in priority based on their clinical need.
- Patients with mental health needs were not always seen in a timely manner and cared for in an appropriate environment.
- The pressures of COVID-19 meant the service struggled at times to have enough nursing staff, but measures were taken to ensure staff were brought in where possible to reach safe numbers. The trust and the nursing leadership were aware of this and it was under review.
- The service did not have enough medical staff to meet the recommended guidance for the department. There was no full-time paediatric consultant and mitigations were not always effective, with no specific rostering of staff to the paediatric area. The rota was not always meeting planned levels and there was a reliance on locum staff to fill gaps.
- Staff kept records of patients' care and treatment. However, we found records were not consistently completed.
- The trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, to receive timely treatment. Performance data showed delays in patients both accessing the emergency department and waiting to be seen. Improvements had not been sustained within the emergency department for effective patient flow.
- Leaders within the emergency department were new in role and support was being provided to help develop them in their role. Although leaders told us about the priorities and issues the service faced, these were not being effectively managed, or risks being appropriately mitigated. Emergency department leaders were visible and approachable in the service for patients and staff. There were long standing cultural issues within urgent care which were being addressed. Staff were focused on the needs of patients receiving care.
- Risks and issues were not always identified or appropriate actions taken to reduce their impact. Although there were systems to report and understand performance, data was not always easily accessed or visible.

Urgent and emergency services

However:

- Staff understood how to protect patients from abuse and acted on any concerns. There were plans to address where safeguarding training was not meeting trust targets.
- Patients had an assessment of their infection risk and other clinical risks on arrival at the emergency department, and staff allocated them to the correct area.

Areas for improvement

We took action under our enforcement powers by issuing a Warning Notice served under Section 29A of the Health and Social Care Act where the quality of health care requires significant improvement. We found areas for improvement including two breaches of legal requirements the trust must put right. We found nine things the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent beaching a legal requirement, or to improve service quality. For more information, see the 'Areas for improvement' section of this report.

How we carried out the inspection

We visited the emergency department. We spoke with staff to include leaders for the emergency department, and medical, nursing and administrative staff. We looked at patient records. We also reviewed trust policies and procedures and performance data

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Safeguarding

Staff understood how to protect patients from abuse and acted on any concerns. There were plans to address where safeguarding training was not meeting trust targets.

Staff we spoke with were clear how they would identify patients they felt were at risk of abuse and the processes followed to report safeguarding concerns. The trust used an electronic dashboard to record and identify patients where there was a known safeguarding concern. The trust safeguarding team was available to provide safeguarding support and advice to the emergency department staff.

Due to the COVID-19 pandemic face to face safeguarding training had been unable to run, and therefore staff accessed their training through e-learning. Staff told us they received training and updates. However, some staff felt more training would be beneficial.

The trust was working on plans to address any shortfalls in training which had resulted due to the COVID-19 pandemic. The trust submitted data for 1 March 2021 which showed safeguarding training compliance for nurses. There was 100% compliance for safeguarding level one training which was accessed through an e-learning package. For safeguarding

level two which was a combined adults and children training accessed by e-learning there was 91.53% compliance. The trust safeguarding level three children training was mandatory for band six staff and above, this was currently at 68.75% compliance and further support was required for staff to complete this training. The trust did not supply data for medical staff safeguarding training compliance.

Cleanliness, infection control and hygiene

We were not assured patients were safe while they waited in crowded areas and we identified lapses in practice around infection prevention and control.

There was an increased risk of nosocomial infection where patients were waiting in crowded areas. The inspection team observed the senior triage assessment rapid treatment (START) area, where patients access the emergency department and are triaged, was a bottleneck with a significant backlog, and this resulted in crowding. There were three cubicles for patients to be assessed and outside of this area a further three patients waited on ambulance trolleys awaiting access to the cubicles for assessment. There was no distancing between the patients and ambulance crews who waited with the patients. Individuals were near to each other and unable to follow the two metres social distancing COVID-19 requirements. Patients were also being cared for in areas not intended for clinical use. These areas were being routinely used. Spaces were marked on the floor for patients to be cared for in the corridor or the open middle area of majors; there was allocation for four patients on trolleys in these areas. This was not in line with best practice guidelines set out by the Royal College of Emergency Medicine for Emergency Department Infection Prevention and Control during the Coronavirus Pandemic. During our inspection there were three patients in these spaces for a significant period. It was observed people walked past these patients without distancing, and the patients did not have any form of protection for example masks or screens.

Staff were observed not to be following trust processes and best practice for personal protective equipment (PPE). In the Plym amber area staff were required to wear apron, surgical mask and gloves, and this PPE should be worn at all times as stated in the trust's "Plym ED (COVID) Handbook", eye protection was also required if providing swabbing or other cough inducing activity. However, during our inspection we did not observe staff in the Plym amber area with this level of PPE.

Staff did have access to appropriate PPE. Staff told us there had been no shortages of PPE and all staff had been face fit tested for tight fitting respirator masks to avoid transmission of COVID-19. Staff told us they had received effective training in putting on (donning) and removing (doffing) PPE safely to prevent the risk of cross infection. Regular updates regarding changes to guidance were made available to staff via emails and bulletins, and staff told us they had been well informed. Staff were aware of the need to socially distance and remain two metres from each other. However, this was difficult to achieve in the hospital environment. Plastic screens were being used in reception areas to reduce the risk of cross infection.

We were not assured staff were maintaining good levels of infection prevention and control. There were limited surface wipes. We observed staff were not wiping down surfaces or computers after or before their use. There were hand gels located by sinks, but staff were not observed to be using them during our inspection. Several staff drink bottles were observed on clinical area work surfaces and there was equipment and general clutter left on surfaces making cleaning difficult. This increased the risk of cross infection. We raised our concerns with the trust and the director for infection prevention and control, consultant nurse infection prevention and control, and chief nursing officer reviewed the

infection prevention control practice within the department during a visit on 16 March. They reviewed the department and found clinical practice was generally of a good standard and observed hand gel dispensers were full and sinks were being used appropriately. They did observe overcrowding and poor social distancing in the START area and staff drink bottles on clinical area work surfaces. This was followed up with actions and further visits to ensure it was corrected.

The trust audited some infection control practice, there were some areas where non-compliance was identified. The trust submitted audits for 1 November 2020 to 28 February 2021 to include a matron audit (covering areas of cleanliness and tidiness), hand hygiene audit and environment audit. The hand hygiene audit found 4.8% of staff did not decontaminate their hands before/after contacts and 4.1% did not decontaminate their hands after removal of gloves. Where there were areas of non-compliance identified the audit did not identify the actions taken. However, a hand hygiene assessment completed did provide evidence of education or advice given if staff were not compliant.

During inspection we did not observe domestic staff in the emergency department completing regular cleaning, despite the department being busy and having a high turnover of patients. We asked staff about this and we were told there was a shortage of cleaners. Senior staff told us as part of safety briefings staff were reminded to clean their areas. We did not observe a high level of cleaning during our inspection. The emergency department risk register includes “departmental deep clean” as a risk, this risk was last reviewed on 4 December 2020 and identified the “department needs to have a deep clean. This is now overdue by two years.” Plans were being confirmed to undertake a deep clean with the housekeeping team, and current mitigation was regular cleaning as per local controls. We reviewed the emergency department cleaning rota and individuals were allocated and followed daily, evening and night-time cleaning schedules. Some shifts were unable to be filled by the usual emergency department staff and we were told in these instances they would endeavour to cover with a member of the rapid response team when they became available. The emergency department had a monthly national cleaning audit, and results for January to March 2021 showed compliance above 98%, observations or areas to action were recorded on the audit.

Staff carried out high-risk processes which may generate aerosols into the atmosphere (known as AGP) in designated areas using full PPE. However, staff told us AGPs may be carried out in the green (non COVID-19) resus area on known COVID-19 positive patients. This was not in line with national infection prevention control guidance, the individual treatment areas are not self-contained leading to an increased risk to other staff and patients in that area. Following inspection, we requested the risk assessment for performing AGPs on COVID-19 positive patients in non COVID-19 areas. The trust’s COVID-19 lead’s response said there was no formal documentation of a risk assessment for this scenario as it should not happen in normal practice, and they were not aware of this having occurred. They confirmed COVID-19 patients were cared for in the COVID-19 emergency department resus area and AGPs completed in line with guidance. Patients who have an unknown COVID-19 status were managed in the green emergency department resus. There was a standard operating procedure for staff to wear full PPE, with additional actions where patients in resus are given a respirator mask if they can tolerate it and moved as far away from the AGP bay as possible. The bay is cleaned 20 minutes after use in line with guidance. There had been no AGPs undertaken on patients who were subsequently found to be COVID-19 positive. The only exception would be in a code red trauma pre-alert on a known COVID-19 patient. However, this had not occurred. It was unclear why some staff told us AGPs were carried out in green resus areas on known COVID-19 positive patients, and the trust should continue to review this.

There were four infection prevention control cubicles for isolating patients. However, some staff felt there was not enough for the number of patients they had experienced coming through the department. Additionally, the clinical decision unit did not have isolation facilities and therefore would need to use an emergency department isolation cubicle. This was identified on the department risk register with mitigation.

Environment

Urgent and emergency services

Given the current pandemic, and limited footprint of the department, efforts had been made to protect patients and staff, but the design and use of some parts of the premises did not always keep patients safe.

The emergency department had been reconfigured in response to the COVID-19 pandemic, to meet national guidance, and to improve patient flow. The trust's COVID-19 lead confirmed they completed walk arounds of the emergency department approximately every six weeks to ensure any changes in layout did not affect the safety profile for patients or staff. There were distinct and separate pathways for patients with known or suspected COVID-19 (red), unknown status (amber) or known negative status (green). The minors department had previously been relocated off the main site but had been moved back onsite in December 2020. Patients arriving by ambulance, ambulant patients (patients who are able to walk in to the department), and GP referrals would enter the department via a senior triage assessment rapid treatment (START) area. The area for paediatrics was separate.

The environment resulted in crowding. Patients were being cared for in corridors which resulted in poor patient experience. In addition to the infection control risks, we found patient dignity and privacy was compromised whilst they waited on trolleys, and it was observed some patients had no blanket or a pillow and were positioned near an opening outside door. Furthermore, patients waiting in the central area of majors could overhear confidential conversations about patients, which risks patient confidentiality. There was a risk on the emergency department's risk register related to overcrowding, which was last reviewed 19 February 2021, the trust continued to review actions and make improvements for department flow to reduce crowding.

The changes to the layout of the department had resulted in staff feeling departments were more disjointed and reduced their visibility of patients. For example, the reception area was now cut off from the main emergency department area. Staff told us at night this left them feeling more vulnerable. When ambulant patients arrived and waited to be triaged in the START area, it was more difficult for reception staff to swiftly escalate any patient concerns, where previously they could call to colleagues they now had to walk to the area.

The trust was not always able to have defined pathways for COVID-19 and non COVID-19 patients, although aimed to manage this within their footprint and mitigate risks. For example, patients on a COVID-19 pathway who needed to be admitted to a hospital ward or be taken for imaging would need to be transported through the minors waiting area. The trust's "Plym ED (COVID) Handbook" identifies this as a transit zone which is an area where patients with possible COVID-19, who are wearing a mask, may be encountered at a distance. These areas do not require PPE if not involved in patient care, other than a clinical mask. There is a recommendation in the handbook to not loiter in transit zones. However, in the minors waiting area patients spend time while they wait to be seen and the trust should review the risk assessment for this.

The trust had socially distanced chairs for use by patients whilst they waited. However, patients did not comply with this when areas were crowded. Seats in waiting areas were marked with tape to indicate they were not to be sat on and enable social distancing between patients. We observed patients sitting on these seats, and therefore were not appropriately distanced. The trust's completion of the royal college of emergency medicine best practice guideline recommendation checklist recorded although spaces are marked, there is no policing and they are sometimes ignored. In order to minimise risk, patients were however required to wear face coverings.

The paediatric area was secure and had appropriate facilities for the care of children. The area had not changed since the pandemic, and was a separate unit to the main department, with a separate entrance. The reception area was

shared with the ambulant adult patients accessing the minors area. There was a large waiting area within the paediatric area which was well equipped and easily visible to staff. However, the layout of the paediatric area in a square made it difficult to observe patients in the cubicles on the back corridor, which posed a risk of responding if a patient deteriorates.

In the paediatric area there were no cubicles designed for assessing adolescent mental health patients, there were no ligature free cubicles. Staff told us children and adolescents with mental health would be cared for in any cubicle although when possible, the cubicles nearest the nurse station were used. None of the cubicles had direct line of sight from the nurse station. We were told if patients were accompanied by an adult they were asked to stay with the young person. The nursing staff said they tried to stay with the individual if possible if they were deemed high risk, but this was often not possible because of other work in the area. There was a risk children could be left alone in an area where there is a ligature risk. We requested the protocol for adolescent mental health patients in the emergency department. This process identified when a young person presented following self-harm to ensure the child was assessed and triaged and seen in the most appropriate venue to meet their need. It was not clear what the process was for young people who were unsupervised, and how their safety within the department was assured. The trust did identify a risk on their risk register of patient self-harm due to ligature points within the department and identified mitigations to address some of these risks.

Staff felt vulnerable when caring for adolescent patients with aggressive or violent behaviour. The only call system was the single medical call button in each cubicle usually on the opposite wall to the only exit door. Staff did not have personal attack alarms or similar. Staff told us on occasions due to aggressive behaviour they felt unsafe.

The assessment rooms for adult mental health patients were compliant with national quality standards from the Psychiatric Liaison Accreditation Network. There were two fully equipped mental health assessment rooms with all the appropriate facilities, including CCTV outside the rooms.

Assessing and responding to patient risk

We were not assured there was adequate oversight and responsibility of the patients who were waiting to be seen and patients were not being seen in priority based on their clinical need. Patients with mental health needs were not always seen in a timely manner and cared for in an appropriate environment. However, patients had an assessment of their infection risk and other clinical risks on arrival at the emergency department, and staff allocated them to the correct area.

All patients were assessed for their risk of COVID-19 on entry to the emergency department and directed to the correct pathway. All tests needed to be sent to the in-house laboratory for processing, which added some delay to admitting the patient into a bed. However, there was standard operating procedures for the amber and red pathways so patient care was not delayed while waiting for the result.

We were not assured there was adequate oversight and responsibility of the patients waiting to be seen, which posed a risk to patient safety. There was a risk patients' clinical needs were unknown, and patients' conditions could deteriorate, if there is not a clear system for the oversight or responsibility of patients waiting. Patients entered the department via a senior triage assessment rapid treatment (START) area. This includes both ambulance arrivals and ambulant patients. During the inspection the triage process and flow for the emergency department was reviewed through observations and talking with staff. There were regularly ambulances queueing outside the emergency department. For example, at approximately 2pm the longest ambulance wait was 54 minutes and three patients were in ambulances outside waiting in excess of 30 minutes. The inspection team spoke with staff who were external to the trust including two ambulance

crews and a hospital ambulance liaison officer (HALO). They described delays in patient handovers from the ambulance and how this was a common occurrence. Flow was described as stopping and starting, with a bottleneck in the START area. This was also observed by the inspection team. When asked, the HALO was not aware of the clinical need of patients waiting in the ambulances, although told us they were booked into the emergency department and assumed the emergency department were therefore aware. The inspection team spoke with several trust emergency department staff to ask who was responsible for the patient waiting in the ambulance, and the response was it was the responsibility of the ambulance crew. As a result, the staff within the emergency department were reliant upon the ambulance crews identifying and escalating concerns if the patient waiting in the ambulance deteriorated, which posed a significant risk to those patients. The emergency department staff and HALO we spoke with were unaware as to what was wrong with the patients as they waited to be seen in START. Those patients had received no prior triage. During a leadership conversation, the inspection team followed up the concerns they had identified. Matrons explained how they would check patients waiting and would walk the areas. However, while the inspection team were onsite this was not happening and there was no contingency when the matrons were not available. The trust did not have a standard operating procedure to provide clarity for themselves and ambulance staff who was responsible for these patients. There were no risk strategies being completed to enable the trust to be assured the care being provided was risk assessed and safely managed. The emergency department risk register did identify a potential risk of harm to patients as a result of delays in ambulances being able to hand patients over due to crowding in the emergency department. However, the risk was not being well managed.

Patients were not being seen in priority based upon their clinical need or in a timely manner. Patients were being seen in turn and not based on clinical priority. There was no safe process embedded for triage to ensure patients were treated in accordance to their clinical need. We observed three ambulant patients waiting a significant period to be seen, the longest waiting for triage was 124 minutes. One patient did not have their reason for attendance recorded and therefore staff were not aware of the patient's clinical need, two patients' clinical needs indicated they should have been seen more urgently than their current wait.

Data showed time to initial clinical assessment was not meeting the 15-minute target. The trust's median minutes for patients waiting in December 2020 was 24 minutes (England average 8 minutes) and in January 2021 21 minutes (England average 8 minutes). This was worse when compared to other trusts. (*source - NHS Digital Accident and Emergency Quality Indicators*)

Following inspection, the trust told us the HALO's role was to monitor the clinical need of patients waiting in the ambulance. When arriving, patients were seen in order for initial assessment or triage unless there were clinical concerns. If there were clinical concerns this would be highlighted immediately and recorded on the electronic system as a triage category. Patients were then seen for their full secondary assessment according to triage category. All triage trained staff were reminded patients must be seen in priority order rather than time order.

Following our inspection, we shared with the trust our immediate safety concerns for patients while they waited to be seen. The trust responded with actions they would take to mitigate the impact to patient safety while they continued to review and action the issues around access and flow.

Staff were not clear how patients waiting on trolleys in areas not intended for clinical use had ongoing monitoring. During the time on site for the inspection, there were several patients waiting on trolleys. The ongoing monitoring of these patients was not clear. If monitoring was required staff told us the patients would need to be moved into a bay area. The trust confirmed patients were risk assessed as to who was appropriate to wait in these areas, and a healthcare assistant was allocated to this area to ensure observations were taken regularly. Patients identified as safe to wait in this area do not have or require continuous telemetry monitoring.

Urgent and emergency services

Patients had observations completed using the national early warning system (NEWS 2). The NEWS 2 audit from August 2020 to March 2021 (review of 4,799 patient records) identified appropriate level of compliance for observations being completed, correctly scored and escalated and documented as per the NEWS trigger threshold. The paediatric early warning score (PEWS) was completed for children. The PEWS audit from August 2020 to March 2021 (review of 261 patient records) identified some areas of non-compliance. Areas which were flagged (less than 95% compliant), on average for this period, showed 90% of PEW trigger was documented, 84% had their frequency of observation increased and 89% had their doctor parameters filled in. The audit did not provide evidence of action in response to areas of non-compliance and sharing of findings with staff to raise awareness for improvements.

Reception staff overseeing the waiting area were given information sheets to identify any red flags for patients deteriorating, this included what to look out for in both adults and children in the emergency department. Staff told us patients were more challenging as waits to be triaged or assessed were often long, this also increased the risk patients may deteriorate.

Patients requiring access to mental health support did not always receive care in a suitable environment by staff with appropriate skills and knowledge. The COVID-19 pandemic had resulted in more mental health patients, both adult and children, attending emergency departments. The increased number of patients with mental health concerns presenting at the trust mirrored the national picture.

The adult mental health pathway in the emergency department was to triage to the clinical decision unit (CDU). The criteria to admit to the CDU was to take general patients who require 24-48 hours in hospital for additional observation. However, the CDU regularly cared for mental health patients who were awaiting a mental health assessment and we were told of one example where a young person with mental health needs had waited in the CDU for a week for a suitable bed. There were occasions when the ten bedded unit had six high risk patients with mental health needs. The triage process for the mental health pathway included a risk assessment and level of observation required. If high level of observation was determined, staff would need to consider an application to the bed watch team. At the time of inspection, we were told this service was not available and the mitigation was to use healthcare assistants from the bank. This included an additional adult healthcare assistant or a trained mental health healthcare assistant who could support CDU. There was also support from security if required. Staff told us they were not always confident in their training to support these patients and would like additional training. Senior staff told us they were concerned staff and other patients were at risk from assault. There were no personal alarms for staff in the department and if staff on CDU or in emergency department were threatened by patient behaviour, they would not be able to call for help without using the crash bell which may be out of reach. The potential risk of harm to patients presenting with mental health conditions and current provision of mental health services was included on the emergency department's risk register as a serious risk. There had been an increased number of incidents relating to patients presenting with mental health problems, including several patients absconding, attending with repeating behaviours, attending with no physical concerns and the delays in access to the psychiatric liaison service. The mental health pathway and the current service provision was being reviewed.

The trust provided conflict resolution training and had been engaging with training following a series of incidents of violence and aggression, this aimed to reduce the risk of harm to staff and patients. Level one training was completed once every three years and became mandatory in September 2020 for all front facing staff. Compliance was at 53.21% for emergency department and 73.88% for CDU. Level two and three training was offered to staff identified as working in high risk areas and was completed annually. Compliance in total for the emergency department was 25.81%, for the

emergency department nursing compliance was only at 8.19%. The trust had faced challenges to deliver face to face training as a result of the COVID-19 pandemic and capacity, but emergency sessions had been delivered for the CDU and compliance was at 64.71%. Records showed some staff were booked for their training which would improve compliance. We were not provided with data for healthcare assistants from the bank.

There was an increased number of patients who were being put on a section 5(2) of the Mental Health Act on the CDU, to hold patients for 72 hours in the emergency department. This was being used to mitigate the risk of the patient absconding while waiting for a review and assessment with the psychiatric liaison team or for a mental health assessment. The trust completed an audit in August 2020 on the use of section 5(2) powers, reviewing 10 cases at random. The audit identified 30% of patients absconded whilst under the section 5(2). The audit outcomes stated there was appropriate use of a section 5(2) in all cases as all patients went on to have a formal Mental Health Act assessment. However, it highlighted there was inadequate supervision/environment which had led to the patient being able to abscond. In February 2021 an email was shared from a consultant, following discussion with external mental health providers, and as an interim measure a decision was made to lower the threshold instituting a section 5(2) assessment where there is a perceived risk of the patient absconding, in discussion with the psychiatric liaison nurse.

Mental health patients were not always reviewed in a timely manner. The psychiatric liaison team were provided by an external provider. Staff told us there were long waits for patients to be assessed. This was supported by the trust data for liaison psychiatry emergency department average response time, where a target was for response within 60 minutes. Data showed the weekly average response times for 17 weeks, between November 2020 and February 2021 was consistently over 60 minutes (except for two weeks). The longest average wait was 179 minutes in the second week of February 2021 where referrals were at their highest at 65 referrals. However, during our inspection a member of the psychiatric liaison nursing team was based in the START area to accept mental health referrals directly, to help ensure patients were assessed in good time. This was part of a trial funded by winter pressure monies. The trust confirmed three patients were referred to the psychiatric liaison team on the day of inspection via this process.

Nurse staffing

The pressures of COVID-19 meant the service struggled at times to have enough nursing staff, but measures were taken to ensure staff were brought in where possible to reach safe numbers. The trust and the nursing leadership were aware of this and it was under review.

The COVID-19 pandemic has brought pressure to all hospitals in the country due to staff either becoming infected, being required to self-isolate after contact with a positive person, or from the usual sickness which afflicts staff at times. There was also pressure from patients needing more care, additional time needed to apply and remove PPE, and a reduction in the availability of temporary staff. This was coupled with a national shortage of nursing staff before the pandemic.

Nursing staff in the emergency department included two matrons as the senior leads and nursing and healthcare assistants across different NHS bands. The department was supported by military staff. The pandemic had enabled a higher number of military personnel to be available to the trust.

Staff told us staffing had been a challenge and they felt they needed more nursing staff to support the department. When staffing was not meeting planned levels, the trust would use bank staff or redeploy nurses into the department from other areas. An emergency department staffing review for nursing, dated March 2021, identified current and

desired staffing for the different departments (paediatrics, minors, majors and education). There were areas where further staffing had been requested to uplift staffing numbers. The report identified the skills of band five nurses required development with an increase in the education team needed to support this. Following the review, a plan had been developed to focus on developing the skills of staff over the next 12 months.

The number of paediatric trained nurses working within the department meant they were compliant with Facing the Future Standards for Children in emergency care settings. This meant the department was always staffed with two registered children's nurses. Data showed staff were up to date with appropriate paediatric intermediate life support.

The emergency department risk register identified some areas of risk for their staffing. This included the current use of a triage system which was unsuitable for the junior nursing staff, and a suggestion of a more reliable triage system which could be implemented in line with changes to the trust's electronic systems. To mitigate this only experienced nurses were identified to triage. However, this was limited as the emergency department had a high number of junior staff.

Nursing competencies were under review and data was being collected. We were told staff were aware of the Royal College of Nursing competencies and books at level one and two. However, this wasn't currently an embedded process. The plan going forward was to ensure all staff were aware of how to correctly complete the document with relevant support. Mental health competencies were being reviewed in line with new training. Staff were also required to complete competencies in trauma nurse training.

Medical staffing

The service did not have enough medical staff to meet the recommended guidance for the department. There was no full-time paediatric consultant and mitigations were not always effective, with no specific rostering of staff to the paediatric area. The rota was not always meeting planned levels and there was a reliance on locum staff to fill gaps.

The department met the Royal College of Emergency Medicine (RCEM) workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK, which recommended consultants to be on duty in the department from 8am to midnight in all medium and large systems.

Despite meeting this requirement, there were not always enough medical staff to ensure safe care and treatment. Staff told us the medical rota provided adequate cover on weekdays. However, we observed from the rota the trust relied on locum cover regularly. Staff told us the weekend rota was understaffed and resulted in significant delays to care. There was no risk on the risk register related to these concerns.

A staffing proposal titled "START/ED Reconfiguration Staffing" published in September 2020 recommended staffing arrangements in line with the reconfiguration of the department. The document identified the department as being understaffed to efficiently assess the average daily attendances, being understaffed out of hours (specifically at 2am), and not having adequate numbers of senior decision makers to staff all zones. The document outlined current daily core staffing for medical staff. This showed appropriate minimal consultant cover from 8am to midnight in line with guidance. Further medical cover was also provided by middle grade and junior staff to cover the department 24/7. There was an additional 11am to 7pm consultant shift, however this was not part of the core staffing and was not always reliably filled from current consultant capacity. At the weekends it was reported within the proposal there is reduced consultant cover and dependency on locums to fill all middle grades and junior shifts.

There was no full-time paediatric consultant employed for the emergency department. The trust was therefore not complying with the Facing the Future Standards for Children in emergency care settings, which states every emergency department treating children must be staffed with a paediatric emergency consultant with dedicated session time allocated to paediatrics. The emergency department risk register identified a risk to patient safety due to absence of a sustainable 24/7 medical cover in paediatric emergency department. Medical cover was not provided on a regular reliable basis due to other demands on medical staff. Paediatric admissions accounted for 27-29% of emergency department admissions. Mitigating actions, to reduce the risk posed by this, recorded on the risk register included an advanced clinical practitioner with specialised paediatric training and a senior registrar who rotated into the department from the paediatric department once a week. In the event of urgent support being required, staff within the paediatric emergency department called for the emergency department medical team or for urgent assistance from the paediatric ward. The trust confirmed further mitigations, to include a paediatric consultant who worked half their time in the hospital's paediatrics and half their time in the emergency department, and additionally an emergency department/paediatric emergency medicine consultant whose recent job plan included working in the paediatric emergency department. There was also a paediatric trained acute care practitioner who spent a day a week in the paediatric area. It was possible to bypass formal emergency department medical review and transfer patients directly to the children's assessment unit for assessment. This was considered on a case by case basis and dependent on workload across the children's assessment unit and paediatric ward.

We were concerned in the absence of a paediatric emergency medicine consultant on duty within the department, medical response would be delayed. In the absence of the paediatric emergency medicine consultant there was no evidence cover was clearly identified and allocated. On the day of the inspection, there was a call on the tanoy at 4.05pm to ask for a "doctor to come to paediatrics", approximately four minutes later a further call was put out saying "doctor to paeds now". A group of doctors were then overhead by the inspection team discussing who would attend before responding which added further delay. Following the inspection, the trust confirmed an emergency department consultant with a special interest in paediatrics attended the second call to the paediatric area immediately. Paediatric staff told us when there was no allocated doctor, this would lead to long waits for children to be seen. We were told when a doctor was allocated to the area staff felt much less vulnerable and this improved patient safety and reduced any risk. There had been no collection or review of data to compare the difference to a doctor being allocated to the area compared to when they had not, but staff told us delays were much less frequent when someone was assigned. Staff provided examples of when they had difficulties getting a doctor from the majors area to see patients they considered to be seriously ill. We were told paediatric emergency department staff sometimes refused to take seriously ill children in the children's area because of this concern and requested they were seen in the main resuscitation room. There were no seriously ill children in the department at the time of our visit for us to observe this in practice, and we were not aware of any incidents or harm caused as a result.

Records

Staff kept records of patients' care and treatment. However, we found records were not consistently completed.

There were varying degrees of quality of the completion of patient records. We reviewed eight sets of patient records, which were all held in paper form. Each set contained the national emergency department safety checklist, which was a tool required to be completed hourly which covered completion of observations, whether a patient was undressed, and if a patient had received food and drink, was present in all patient records. However, these had not been consistently completed in full every hour for all patient records reviewed. We reviewed the matrons audit for the date range 1 November 2020 to 28 February 2021, the audit reviewed three sets of a patient's risk assessments to see if all relevant assessments were completed and found from review of five patient records only 40% were completed. The audit did not provide evidence of the actions to address this and make improvement.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

We did not rate responsive this time and the previous rating of requires improvement remains.

Access and flow

The trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, to receive timely treatment. Performance data showed delays in patients both accessing the emergency department and waiting to be seen. Improvements had not been sustained within the emergency department for effective patient flow.

Patients could not all access the emergency department in a timely way and the trust faced known challenges with access and flow. Managers and staff worked to try to ensure patients did not stay longer than they needed to, but the demands on the service and challenges with access and flow did not ensure this was consistently managed. The trust had not sustained improvements since the CQC inspection in August 2018 where the trust was told it must "put in place appropriate escalation processes that ensure a timely response to supporting the emergency department to keep patients safe and improve patient flow". The trust responded to this requirement notice within their action plan. However, this inspection identified similar themes continued which impact on patient safety and patient flow.

Performance data showed delays in patients both accessing the emergency department and waiting to be seen. There was a risk patients were unable to access care and treatment in a timely way. There was also an additional risk to the system when ambulances are held for long periods of time and unable to respond to other calls where patients require timely care and treatment.

Ambulance handovers

Ambulance handovers were not in line with standards for an ambulance handover (clinical handover and offload) to be reliably completed within 15 minutes of arrival.

The trust's integrated performance report presented to the January 2021 board identified 855 hours of lost ambulance time in November 2020. The report describes ambulance handover volumes increasing significantly as well as delays with handovers. Data shows from June 2020 ambulance waits over 30 minutes and 60 minutes were a regular occurrence and were not improving. (*source – University Hospitals Plymouth NHS Trust Integrated Performance Report*)

Data from NHS England showed between 22 February and 7 March 2021, 21.3% of ambulance arrivals were delayed 30 to 60 minutes, compared to an England average of 6.0%, and 14.9% of ambulance were delayed over 60 minutes compared to an England average of 1.4%. (*source - NHS England Urgent and Emergency Care daily sitrep*)

Time to definitive treatment

Urgent and emergency services

Data showed for the trust the median minutes patients waited in December 2020 for time to treatment was 109 minutes (England average 43 minutes). There is no target for this measure, but this was worse when compared to other trusts. In January 2021 the median minutes was 105 minutes (England average 39 minutes) which was similar when compared to other trusts. (*source - NHS Digital Accident and Emergency Quality Indicators*)

Patients waiting in the department more than 12 hours after arrival

The trust had reported breaches of the 12-hour trolley standard. The trust's integrated performance report presented to the January 2021 board identified 23 12-hour trolley breaches in December 2020. The report described 12-hour waits had become more prevalent due to the COVID-19 wave. (*source – University Hospitals Plymouth NHS Trust Integrated Performance Report*)

NHS England data showed the proportion of patients waiting more than 12 hours from decision to admit to admission was at 3.80% in January 2021, which was similar when compared to other trusts. In February 2021 the trust was at 2.5%, which was worse when compared to other trusts. (*source – NHS England*)

Four-hour standard

The trust was not required to report on the four-hour standard while they participated in a national pilot. The trust was part of the rapid care assessment pilot trialling the four new standards set out in the NHS review of clinical standards. The NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours was therefore not required to be reported on. The performance data from the new target was not readily available to the emergency department staff, and there was no clear nationally set and agreed benchmark to indicate what good performance would be. This impacted on the ability for the trust to compare performance.

The emergency department's risk register identified a risk of emergency department crowding as a result of lack of inpatient flow and excess demand compared to available capacity. We observed this crowding and lack of flow during our inspection. To improve the patient flow into the emergency department the trust implemented a senior triage assessment rapid treatment (START) process in October 2020. This was introduced to provide a single point of access to ensure equitable access and assessment of both ambulance and ambulant arrivals. All patients arriving went through the START area which consisted of three cubicles; two for ambulance arrivals and one for ambulant care patients. During our inspection we observed this process was causing a bottleneck. Staff told us this was a regular occurrence.

To aid flow from ambulances the local NHS ambulance provider had placed a hospital ambulance liaison officer (HALO), in the entrance to the emergency department. The HALO was onsite from 11am to 11pm seven days a week. Their role was to ensure the smooth offload of patients into the department, to look after ambulance crew welfare, to liaise with the emergency department about patients waiting in ambulances and help manage the flow of ambulance patients into the emergency department.

Patient ambulance handovers were often delayed, as evidenced by performance data and observed during our inspection. During our inspection there were consistently between four and six ambulances outside waiting to transfer patients into the department. This delay meant patients did not receive the treatment they needed in a timely way.

Urgent and emergency services

The ability to see, on electronic systems, the patients arriving by ambulance had been implemented in the emergency department a month prior to our inspection, therefore it was not yet fully embedded in practice. The emergency department received on average 120 ambulance cases per day. The patient booking system for the emergency department included the registering of patients in the ambulances on a separate but visible screen, prior to them being triaged and risk assessed. This alerted staff within the department of the number of patients waiting in the ambulances.

Information was available to staff at all times, but it was not easy for staff to readily identify how long patients had been waiting to be seen, treated or transferred/discharged. Staff were required to view multiple screens for the information which further impacted on their ability to manage the flow within the department.

The systems to promote flow were not always effective, with the increasing demand for the emergency department outweighing the capacity available within the trust. The wider hospital flow was impacting on the emergency department, and emergency department staff felt they were the ones who bore the risk. Several factors impacted on capacity and demand, including; increased numbers of patients, COVID-19 social distancing and additional cleaning required, and the lack of available beds to admit patients. During this inspection we did not review the wider hospital support. However, there was limited evidence of pull from the emergency department by the wider hospital. Staff perception was the emergency department did not have the control over the patient flow for the rest of the hospital, making the ability to flexibly react to the capacity demands in the department increasingly difficult.

The trust held regular bed capacity meetings to identify flow, escalation, discharge planning and any potential breaches, these were attended by people with the appropriate skills and knowledge. During our inspection we attended the 5pm bed meeting which covered the emergency department briefing issues and red capacity. The meeting identified there was a shortage of beds available for admission to the wider hospital and as a result 20 patients remained in the emergency department over night while they waited for an inpatient bed.

The senior emergency department team held daily huddles to review the previous days data to identify where improvements could be made and identify solutions. They were supported by a member of the trust's improvement team.

The trust had escalation plans to activate during times of surge. However, staff said they had given up using them as they felt on many occasions it did not result in action. Staff felt they were expected to manage the risk of overcrowding, and the hospital never had space to pull patients into other areas to help reduce the risks of crowding in the emergency department. We requested a copy of the Royal College of Emergency Medicine's best practice guideline checklist completed by the emergency department. The trust returned a completed document and against the recommendation around whether there is an escalation process, the trust had recorded "there is a policy but it has never been effective and so a new policy is being developed. Flow through the department has always been an issue."

Staff told us same day emergency care (SDEC) for patients, which is now a mandated pathway for patients and would take patients away from the overcrowded department, was not being used effectively. Senior staff told us the numbers for treat and discharge within the department was high, versus patients referred to SDEC which was low. The acute assessment unit received direct admissions for patients from the GP or those discharged from the emergency department to return the next day for SDEC, these patients did not always flow through the department.

The clinical decision unit had a remit to take patients who require 24-48 hours in hospital for additional observation. However, staff told us patients would be admitted to the unit, even if they do not meet the criteria, to help with the flow in the emergency department. This meant some patients were not in the most appropriate environment to receive their care, for example patients with mental health needs.

Urgent and emergency services

We found frustration among the senior team who felt the external support from other specialities was limited, which impacted the flow out of the department. Some improvement had been seen following an external review report from December 2020. Since then, the medical team had been more present in the department, to admit patients into the rest of the hospital, but this was not fully embedded in practice and did not extend to other specialities. We were told specialist teams reviewing patients was variable and patients were not routinely seen by medical specialty consultants even if they had been in the department for many hours after referral. The morning ward rounds within the trust would not usually include patients waiting in the emergency department. However, by exception some consultants would review their patients whilst they awaited transfer to the wards. Delayed review of patients impacts on patient care and contributes to the flow issues in the department.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders within the emergency department were new in role and support was being provided to help develop them in their role. Although leaders told us about the priorities and issues the service faced, these were not being effectively managed, or risks being appropriately mitigated. Emergency department leaders were visible and approachable in the service for patients and staff.

The emergency department leadership team included medical leadership via a consultant clinical lead and nursing leadership via two matrons. Over the years there had been a high level of turnover of leaders within the emergency department. Current leaders were reasonably new and were all in their first senior leadership roles. Support was being provided to support and develop these individuals in their role.

These relatively new leaders understood the issues and challenges for the emergency department and had some plans to address these. However, at the time of our inspection the issues the service faced were not being effectively managed, or risks being appropriately mitigated. The emergency department sits within the medicine care group; leaders were present at department and care group level. Staff told us leadership was good and they felt supported. We were told there were good systems for decision making and gaining consensus of colleagues.

The emergency department leadership team told us they were focused on improving performance. They were reinstating their safety huddles, which were now held three times a day. They had previously been stepped down at the height of COVID-19 outbreak. This huddle allowed plans to be made about patients waiting a long time, with the last one held at midnight before the consultant ended their shift. Leaders had also sought external support and visited other trusts to try to understand what worked well and what they could learn from. However, they found restrictions in the improvements they could make as this required a trust wide approach alongside changes to the emergency department.

Staff told us the executive team had recently become more visible in the emergency department. However, it was perceived there was still a gap in the understanding of the department challenges and the ownership from the wider trust of patient flow issues.

Urgent and emergency services

Culture

There were long standing cultural issues within urgent care which were being addressed. Staff were focused on the needs of patients receiving care.

The emergency department staff had been resilient in their response to the ongoing COVID-19 pandemic. However, staff had found their situation challenging and were tired. During our inspection we observed staff delivering compassionate care and maintaining a calm atmosphere and environment, with staff pulling together to care for patients.

The trust and NHS England and Improvement had commissioned an external review which focussed on cultural and relationship challenges, which could have been impacting on the delivery of high-quality safe care within the emergency department. The review took place in December 2020, following several concerns raised externally by staff within the department. The remit of the review was to focus on culture and relationships as key enablers to sustained performance improvement. This was completed to identify the root cause of the ongoing and repeated challenges facing the service. The external review identified areas of improvement needed within the emergency department, wider hospital and across the executive team. Senior leaders within the trust were working with departmental leaders to respond to this. Key themes included culture and relationships, system flow and governance. During our inspection we did not follow up further on culture in the department as this had been covered in detail in the external review. However, it is recognised culture impacts and affects safety and quality. The trust had responded to the review with an assurance and delivery framework and programme plan setting out key actions and tasks with dedicated leads. The trust was presenting their assurance and delivery framework in response to this review to external stakeholders at a system oversight meeting, which met monthly. Internal support was being identified to support staff and external support had also been commissioned. There was dedicated freedom to speak up listening events set up and being held for the department.

Staff reflected on the outcome of the external review. Whilst headlines had been shared, they reported access to the report was not readily available and expressed their concerns over the lack of openness with the full report and restricted way the full report could be seen. Some staff expressed their frustration with the lack of momentum following the review to address, what they believed to be, long standing cultural issues.

A staff council was introduced in October 2020, to encourage staff to speak openly. We were told where there was a reluctance to change, there was now more of an appetite for change in the department.

Managing risks, issues and performance

Risks and issues were not always identified, or appropriate actions taken to reduce their impact. Although there were systems to report and understand performance, data was not always easily accessed or visible.

Our inspection identified areas of risk to patient safety which did not always have appropriate actions taken to reduce their impact. We reviewed audits and found areas of non-compliance identified did not provided evidence of actions to address and make improvements. There was a department risk register and risks were reviewed regularly with mitigating actions recorded. The risk register identified the key challenges within the emergency department to include impact from or for the wider trust and external providers, these risks did correlate with our findings on inspection.

The external review also focussed on governance and the improvement of the emergency department agenda to allow for the focus on risk, issues and performance, and as a result, improved governance systems were being introduced. Quality governance processes had been reviewed and were being aligned. Two new matrons started at the end of 2020 and were putting in structures to manage governance and improve processes. Governance issues were reviewed once a

month by the department, led by the consultants. To oversee improvements an urgent and emergency care assurance board met monthly, chaired by the trust's director of integrated care and partnerships, and an urgent and emergency care operational improvement board was meeting fortnightly chaired by the chief operating officer. Care groups fed into these boards, this included the emergency department improvement group, and the clinical pathways development group/SDEC.

There were processes to report incidents. Incidents were reviewed by the appropriate person and actions identified, for improvements to be made and learning to be shared. We did not find incidents reported always correlated with what staff told us. It was not clear whether staff were reporting these as incidents. For example, when there was not a timely response for paediatric medical cover or where mental health patients were not assessed in a timely manner or not being cared for in an appropriate environment.

We were concerned with the lack of access for the department to real time data. Senior staff told us the new data being reported as part of the pilot had not been readily available, and there was no process to benchmark what good performance looked like. Department live data was available but on separate screens so there was not one dashboard to see a live display of performance, acuity or activity. These are often used well in emergency departments to be able to give staff an understanding of how well the system or department is working and can give motivation for staff if it is used effectively. The emergency department risk register included a risk around their emergency department information system and its limited functionality. A new system was being introduced in autumn 2021.

Performance data from the previous day was reviewed as part of the department daily huddle. The data would be reviewed, and discussions would be held about why delays may have happened and where focus needed to be.

The use of paper records for patients created a reduced opportunity to automate processes, audit records, systems and processes quickly, and to be more responsive to safety and flow issues. The department was planning to move to an electronic patient record later in the summer 2021, however this had now been delayed to the end of 2021.

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.

The urgent and emergency care service must:

- Ensure patient care and treatment is provided in a safe way and risks are being fully mitigated while patients wait to access the emergency department. Ensuring there is adequate oversight and responsibility of the patients who are waiting to be seen, while they wait in ambulance queues or walk into the emergency department, and they are seen in priority based upon their clinical need. Regulation 12(1)(2)(a)
- Ensure patients are safe while they wait in crowded areas. To include appropriate protection in line with COVID-19 infection prevention and control guidelines and for staff to be clear of how they monitor patients while they wait in these areas. Regulation 12(1)(2)(h)

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- Ensure the appropriate personal protective equipment is always used by staff to reduce the risk of infection and prevent and control the spread of infection. The trust must ensure staff are maintaining good levels of infection prevention and control, to include wiping down surfaces and computers following use. High levels of cleaning should be maintained within the emergency department. Regulation 12(1)(2)(h)
- Ensure the mitigations, in the absence of a full-time paediatric emergency medicine consultant, are effective to ensure children are provided with care or treatment by clinical staff with the correct qualifications, competence, skills and experience to do so safely. The trust should ensure there is clear allocation of medical cover (or equivalent) for the paediatric department and timely response to emergencies. Regulation 12(1)(2)(c)

The urgent and emergency care service should:

- Continue to support staff to complete safeguarding training so they are compliant with the training levels required for their role.
- Support staff to complete mandatory conflict resolution training to ensure they are appropriately trained to manage conflict within their work environment.
- Review with staff whether aerosol generating procedures are completed on known COVID-19 positive patients in the green resus area and educate staff in line with trust processes and best practice.
- Review the transfer of COVID-19 positive patients through the minors waiting area, and the risk assessment for the patients who remain waiting in this area.
- Review the care and safety of children and adolescents with mental health who are being cared for in the paediatric emergency department where cubicles are not ligature free, and review with staff their safety and access to support when dealing with aggressive behaviours.
- Continue to review the current service provision for mental health patients and make improvements to pathways to ensure patients receive timely care, are cared for in appropriate environments, reduce incidents of patients absconding and use section 5(2) appropriately.
- Review the completion of safety checklists within patient records to ensure they accurately reflect care and are consistently completed in line with trust processes.
- Continue to review the impact of the wider trust on access to and flow through the emergency department and make improvements where appropriate.
- Look at developing or enabling systems to give a real-time presentation of performance displayed to provide staff with an understanding of how well the system or department is working and give motivation for staff when used effectively.

Our inspection team

The team that inspected the urgent and emergency service comprised a CQC lead inspector, and two specialist advisors.

The team that inspected the diagnostic imaging service comprised of a CQC lead inspector, a CQC inspector and a CQC IR(ME)R inspector.

The inspection teams were supported remotely by an inspection manager and inspector and overseen by Amanda Williams Head of Hospital Inspection.

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

This section is primarily information for the provider

Enforcement actions

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