William Harvey Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

William Harvey Hospital is operated by East Kent Hospitals University NHS Foundation Trust. The trust became an NHS foundation trust in 2009. It has five hospitals serving the local population of around 695,000 people across Dover, Canterbury, Thanet, Shepway and Ashford.

The trust has 1,111 inpatient beds across 54 wards. This includes 31 critical care beds, 48 children's beds and 49 day-case beds. Each year the trust receives over 200,000 emergency attendances, 158,000 inpatient spells and one million outpatient attendances. Both William Harvey Hospital in Ashford and Queen Elizabeth the Queen Mother (QEQM) Hospital in Margate provide all core services while Kent and Canterbury Hospital in Canterbury does not have maternity beds and has a minor injuries unit with an emergency care centre rather than a full emergency department.

NHS Improvement (NHSI) put the trust in financial special measures in March 2017 because it was forecast to be in significant financial deficit and was not meeting its control total (the trust's year-end target against its budget). The trust was still in financial special measures at the time of the inspection.

We inspected urgent and emergency care services at William Harvey Hospital using our focused inspection methodology. However, we inspected all areas that we would inspect on a comprehensive inspection. We carried out an announced inspection on 3 and 4 March 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service stayed the same. We rated it as **Requires improvement** overall because:

- The service did not always have enough staff to care for patients and keep them safe. Staff did not always manage safety well. The service did not always control infection risk well. Staff did not always assess risks to patients, act on them, or keep good care records. They did not always manage medicines well. The service did not always manage safety incidents well or learn lessons from them.
- Staff did not always follow department policy. The service did not always provide patients with pain relief when they needed it. Managers did not always monitor the effectiveness of the service.
- The service did not always plan care to meet the needs of local people or take account of patients' individual needs. They did not always make it easy for people to give feedback. People could not always access the service when they needed it and did sometimes have to wait too long for treatment.
- Staff did not understand the service's vision. Some staff were not clear about their role or accountabilities. Some staff were committed to continual improvement of services.

However:

- The service had made improvement to the paediatric emergency department services since our last inspection.
- Most staff had the training in key skills. Staff understood how to protect patients from abuse.
- Most staff provided evidenced based care and treatment and gave patients enough to eat and drink. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. The service engaged well with patients and the community to plan and manage services.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should take action either because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to help the service improve. We also issued the provider with two requirement notices that affected urgent and emergency services. These requirement notices tell the trust to produce a plan, within 28 days, for how it will comply with regulation 12 (safe care and treatment) and regulation 17 (good governance). Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Requires improvement 	The service provided urgent and emergency hospital services to the people of Southeast Kent. This included; an accident and emergency department, urgent care centre, paediatric emergency unit, hyper acute stroke unit, and ambulatory care unit.

Summary of findings

Contents

Summary of this inspection

Background to William Harvey Hospital

William Harvey Hospital is operated by East Kent Hospitals University NHS Foundation Trust. The hospital opened in 1977 and is in Ashford, Kent. It is an acute hospital which serves the population of south-east Kent. Services include emergency care, elective care, trauma, orthopaedic, paediatric and an urgent care centre.

The hospital is situated in Ashford near two main routes to Europe, the port of dover and the channel tunnel. The area has high levels of migration and increased prevalence of common long-term conditions.

William Harvey Hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Family Planning.
- Management of blood supply and blood derived products.
- Maternity and Midwifery services.
- Surgical Procedures.
- Termination of Pregnancy.
- Treatment of disease and disorder.
- Transport services, triage and medical advice provided remotely.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC assistant inspector and two specialist advisers with expertise in emergency department care. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about William Harvey Hospital

During the inspection, we visited the accident and emergency department, the ambulatory care unit, the urgent care centre, the observation ward, and the resuscitation area. We spoke with 37 staff including registered nurses, health care assistants, reception staff, medical staff, allied healthcare professionals (such as, physiotherapists) and senior managers. We spoke with 13 patients and two relatives. During our inspection, we reviewed 17 sets of patient records.

The hospital has been inspected three times. The most recent inspection was in May 2018, when we rated urgent and emergency services as requires improvement. We also carried out a focused inspection of services for children and young people at this location in October 2018.

Activity (October 2018 to September 2019)

- 229,284 patient attendances at the trust's urgent and emergency care services.
- 46,267 children and young people attended the trust's urgent and emergency care services.
- 37,907 patients were admitted to hospital while attending the trust's urgent and emergency care services.

Track record on safety (January 2019 to December 2019)

- Zero never events for this service.
- Trust emergency and urgent care service had 34 serious incidents.
- 115 complaints.

Summary of this inspection

Services provided at the hospital under service level agreement

- Clinical and non-clinical waste removal.
- Interpreting services.
- Laundry.
- Porters and cleaning services.
- Security
- Mental Health services
- Medical equipment servicing

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- Not all staff had completed mandatory training. Nursing staff had higher compliance rates than medical staff.
- Staff did not always control infection risk well, or use equipment and control measures to protect patients, themselves and others from infection. Staff did not always keep the premises and equipment visibly clean or follow the trust's infection control policy.
- The design and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always complete risk assessments for each patient, remove or minimise risks, or update assessments. Staff did not always identify and act upon patients at risk of deterioration.
- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers did not always regularly review and adjust staffing levels and skill mix.
- Staff did not always keep detailed records of patients' care and treatment. Staff could not always easily access records.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Managers did not always identify learning from incidents. Staff recognised and reported incidents however, managers asked staff not to report repeat incidents. Learning from incidents was not shared with staff. Incidents were not graded in line with the trust policy.

However:

- The service provided mandatory training in key skills including the highest level of life support training to staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff managed clinical waste well.
- The service's nursing staff had the right qualifications, skills, training and experience.

Summary of this inspection

- The service had enough medical staff with the right qualifications, skills, training and experience to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.
- Records were clear, up-to-date, stored securely.
- Managers investigated incidents.
- The service used monitoring results to improve safety. Staff collected safety information and made it publicly available.

Are services effective?

Requires improvement

Our rating of effective stayed the same. We rated it as **Requires improvement** because:

- Staff did not always follow the department's policies.
- Patients were not always given the support needed to eat and drink.
- Staff did not always record patients pain scores. Some patients did not receive pain relief in a timely way.
- Staff did not always use monitoring information to assess and improve effectiveness of care and treatment.
- The service did not ensure all staff completed training on the Mental Capacity Act.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.
- Staff gave patients food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patient's regularly to see if they were in pain.
- Staff used audit findings to make improvements.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.

Summary of this inspection

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

Are services caring?

Good

Our rating of caring improved. We rated it as **Good** because:

- Staff treated patients with compassion and kindness and took account of their individual needs. Staff respected patient's privacy and dignity.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Requires improvement

Our rating of responsive stayed the same. We rated it as **Requires improvement** because:

- The service planned and provided care in a way that did not always meet the needs of local people and the communities served. Services were not always planned together with other local services.
- The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.
- People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The service moved patients frequently within the department without a clear medical reason or in their best interest.
- People were not easily able to raise complaints. Some patients were able to raises concerns.

However:

- The service coordinated care with other services and providers.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Summary of this inspection

Are services well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

- Leaders did not always take action to resolve the issues faced by the service.
- The vision and strategy were not understood by staff and they did not feel involved in their development or implementation.
- The service did not always have an open culture where patients, their families and staff could raise concerns.
- Governance processes were as not always effective. Staff at junior levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss or learn from the performance of the service. The learning from senior staff was not shared effectively with junior staff.
- Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact however, these were not always effective. Staff were not always included in decision-making to avoid financial pressures compromising the quality of care.
- The information systems were not all integrated together. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Leaders did not always encourage innovation and participation in research.

However:

- Leaders had the integrity, skills and abilities to run the service. They understood priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision to improve services and a strategy to turn it into action. Leaders understood and knew how to apply their strategy and monitor progress.
- Generally, staff felt respected and valued. They were focused on the needs of patients receiving care.
- Leaders operated governance processes, throughout the service and with partner organisations. Staff at senior levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- They had plans to cope with unexpected events.

Summary of this inspection

- The service collected data and analysed it. The information systems were secure. Data or notifications were submitted to external organisations as required.
- Leaders and staff openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	N/A

Requires improvement

Urgent and emergency services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are urgent and emergency services safe?

Requires improvement

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

Mandatory training

Not all staff had completed mandatory training. However, the service provided mandatory training in key skills including the highest level of life support training to staff. Nursing staff had higher compliance rates than medical staff.

Nursing staff received and kept up-to-date with most of their mandatory training. Nursing staff had ten mandatory modules. The compliance with these modules was; 99% for moving and handling, 99% for fire safety, 99% for health and safety, 99% for information governance, 100% for infection prevention and control, 98% for equality and diversity, 83% for dementia awareness, 79% for prevent radicalisation, 83% for hospital life support (intermediate life support), and 73% for paediatric life support. The service met their target of 85% for six modules out of these ten.

Medical staff received and kept up-to-date with most of their mandatory training. Medical staff had ten mandatory modules. The compliance with these modules was; 97% for moving and handling, 87% for fire safety, 95% for health and safety, 90% for information governance, 90% for infection prevention and control, 95% for equality and diversity, 11% for dementia awareness, 59% for prevent radicalisation, 62% for hospital life support, and 56% for paediatric life support. The service met their target of 85% for six modules out of these ten. Managers were aware of this and had recently introduced team days. These days were scheduled time for nursing staff to take time away from their face to face duties and were focused on training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had a dashboard that showed them the current compliance with mandatory training. Managers told us they had found it difficult to release staff for face to face training sessions due to pressure on the department.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia as part of their induction, but this training was not part of their yearly mandatory training.

Advanced life support training was provided for medical staff and senior nursing staff. We were told the spaces on this course were limited and managers had difficulties getting enough spaces for all the staff that needed to complete this training. The compliance for medical staff was 93% for advanced life support training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff received safeguarding children level 3 training with a compliance

rate of 85% which met the trust's target. Nursing staff received safeguarding vulnerable adults' level 2 training with a compliance of 83% which was just below the trust's target of 85%.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff received safeguarding children level 3 with a compliance rate of 81% which was below the trust's target of 85%. Medical staff received safeguarding vulnerable adults' level 2 with a compliance of 59% which was below the trust's target of 85%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described to us when they would need to make a safeguarding referral and showed an understanding of the different types of abuse. We saw a detailed record of when staff had identified a safeguarding concern.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with told us how they would report their concerns. We saw staff identify a safeguarding concern that they then reported, and they acted to protect the patient from immediate risk of abuse.

Staff told us that in their safeguarding training they had been informed about female genital mutilation. This included how to identify this, when and where to report this and what support was available. This training also covered the national prevent program focused on the prevention of radicalisation of people into terrorism.

Cleanliness, infection control and hygiene

Staff did not always control infection risk well, or use equipment and control measures to protect patients, themselves and others from infection. Staff did not always keep the premises and equipment visibly clean or follow the trust's infection control policy.

The department had an infection control policy, but staff were not always following it. A senior nurse told us they would clean a blood spillage with an incontinence sheet and a detergent based cleaning wipe. The trust's policy stated a chlorine-based cleaning solution should be used to clean a blood spillage.

Staff followed aseptic non-touch technique however, the environment did support safe clean procedure to be carried out. During the inspection we saw, on three occasions, staff inserting cannulas in to patients in a corridor. These staff followed aseptic non-touch technique but with visitors, patients and staff squeezing past their sterile field during the procedure. We were therefore not assured staff had maintained a safe clean procedure throughout the cannular insertions. We observed staff did not always follow to aseptic non-touch technique when administering intravenous medicines.

At the time of the inspection the emergency department had a coronavirus testing pod outside the building in the ambulance parking bay. Entrance doors to the emergency department had information for patients with suspected coronavirus directing them to stop and not enter the department. There were directions to the pod and guidance for patients to follow when inside the pod. During the inspection we saw the pod's door inappropriately being held open by a traffic cone after being cleaned. We highlighted this to the nurse in charge who acted to close the door.

The department looked visibly clean. Staff and patients' toilets were visibly clean. Each patient toilet had an electronic satisfaction screen where users could rate the cleanliness of the facilities using a scale of pictorial faces. We saw waiting areas looked visibly clean. However, the tops of both resuscitation trollies we looked at were visibly dusty.

Equipment waiting to be cleaned was not always suitably stored. A cage of dirty pillows was stored in the corridor behind the majors area. The cage had a handwritten sign saying "A+E pillows need to be cleaned". Dirty items stored where patients and visitors could come into contact with them was an infection risk.

The flooring was in good condition and built to meet the national standards to support effective cleaning. Curtains were visibly clean and were all dated and changed within the last six months in line with trust policy and national guidance.

General cleaning in the department was carried out by an NHS-owned subsidiary company of the trust. We saw staff

from this service were available in the department throughout the day and night. Cleaning of toilets was scheduled but cleaning of cubicles and other patient areas was done after each patient.

Staff did not always follow infection control principles. We saw two staff that were not bare below the elbows. Staff used the correct personal protective equipment (PPE) and washed their hands in line with universal precautions and the World Health Organisation's 'five moments of hand hygiene'. Couches were wiped down between patients and disposable paper couch roll was used in line with the trust's policy. The department responded to potentially infectious patients, staff were trained to use specialist PPE and carried out their roles to support patients through the required testing. We saw PPE was readily available including aprons, gloves and masks. Handwashing sinks and hand sanitiser gel were available.

Staff did not always protect patients and other staff from the risk of exposure to blood and body fluids. We saw a sample of blood in a syringe had been left on the side next to the department's blood analyser unattended and unlabelled for over 30 minutes. We highlighted this to staff who then quickly and safely disposed of this sample.

To help reduce the risk of infection the seating in the reception area were covered with a wipeable fabric. However, chairs in the majors assessment area were not all covered in a cleanable material, making them harder to clean and an infection control risk. Managers were aware of the risk and there were plans to renovate the seating in this area.

The department used audits to monitor the standard of infection control practices. These included hand hygiene audits, commode audits and environmental audits. We looked at two commode audits and these showed 100% compliance. An environmental audit showed the department was mostly compliant with this audit but also highlighted some areas for improvement. Some of these areas of improvement had actions planned to ensure future compliance. This included identifying the store room had clutter on the floor and asking staff to move this off the floor to facilitate cleaning. However, other areas of noncompliance did not have actions listed against them or in the action plan attached. This meant opportunities to improve patient care were missed.

The trust had a safe handling of sharps policy and needle stick guidance. Staff told us about two recent needle stick injuries and after both incidents the trust's policy had been followed by staff for the treatment of a needle stick injury. However, there was no information about the needle stick procedure in the clinical rooms.

Sharps were not always managed in line with trust policy which placed staff and patients at risk. While sharps boxes were assembled correctly, we found two which were over filled and one which was stored in an area which if a door was triggered to close would result in the bin being knocked over.

The trust had helped protect their patients from seasonal flu. The trust's vaccination programme for seasonal flu had vaccinated 77% of frontline staff and 71% of all staff by January 2020.

Environment and equipment

The design and use of facilities, premises and equipment did not always keep people safe. However, staff managed clinical waste well. The department had made improvement to their paediatric assessment unit from our last inspection.

Not all patients had access to call bells to alert staff to their needs. On the first day of the inspection we spoke with a patient being cared for in a corridor that did not have a call bell. On the second day of the inspection we saw a member of staff issuing a call bell to a patient, in the same place. This staff member told the patient that they needed one as they were out of the line of sight of staff.

The department did not always meet the national target of triaging patients who had walked into the department within 15 minutes. The department had a patient journey map to inform patients how their journey through the department progressed. This covered the pathway from entrance to the department to either admission or discharge. Each bed bay displayed information boards explaining to the patient what stage they were in on the process. However, patients in corridors would be unaware of this information. These signs had a similar style making it easy for patients to spot the information.

On the map, there was information indicating walk-in patients should expect to be seen by triage within 20 minutes. However, the national target for triaging patients that walk in was 15 minutes.

Patients were placed at risk as the department was not secure. Doors to the department could not be secured or the locking system was not working. The automated doors, used by the ambulance crews, were freely swinging open without the need for a code. At least one open door provided free access to the main hospital. This meant unauthorised people would have direct access to the main emergency department and children's emergency department. We highlighted this to a member of staff who arranged for an engineer to fix the door.

Maintenance of the department's equipment did not always protect patients and staff. A door to a sample chute system was unsecure. This system uses vacuum tubes to send samples to be analysed. When examining the system, a returning pod fell on to the floor which could have struck a person. We highlighted this to a member of staff who said this should have some form of latch or lock to stop unauthorised access.

Patients and staff were placed at risk because fire safety measures were not always followed. We observed a door to a linen cupboard, clearly labelled as a fire door to be kept locked which was left open. On one occasion a patient in a bed was left in a position which obscured a fire door. In other areas equipment was being stored in areas which blocked fire doors and exit routes. In the event of a fire the doors would not be effective in preventing the spread of fire or smoke and exiting the building could be difficult.

The door leading from the seated majors waiting room to ambulatory observations had boxes of printer paper stored behind the door causing a hazard and meant the door did not open fully. This may have caused a hazard if patients needed to be evacuated in an emergency.

We observed staff having difficulties in moving beds through doorways in majors. This was due to beds being in the corridors and blocking walkways. Bed rails needed to be lowered so they could pass through. This meant if an evacuation was needed it would have been delayed.

The design of the environment did not always follow national guidance. The main waiting room for adult patients was not observable by staff. We saw a patient that should have been identified as deteriorating but was not identified until our inspection team found a nurse to highlight this patient's needs to them.

The paediatric emergency unit was well organised, separate from the adult section and included a separate paediatric waiting area which was bright and colourful. There was a resus cubical for paediatric patients although this was not in the same area as the rest of the paediatric emergency unit. The resus cubical was a dedicated cubical in the adult's resus area.

The environment was not designed in a way to promote the safety of patients. The department was overcrowded. Staff told us the number of patients was common showing that the unit was not large enough to safely accommodate the number of patients. Managers told us they had approved plans to expand the department which would be starting in April 2020. The ambulatory care unit was designed for seven ambulatory patients (patients able to walk and fit to sit) to sit in chairs. When we visited the ambulatory care unit there was three patients being cared for in chairs and five patients being cared for in beds. Staff told us this was routine practice showing that this area was not designed for the purpose it was being used for.

Staff did not always have enough space to use equipment safely. We saw staff inserting cannulas into patients in corridors. On one occasion, a member of staff was inserting a cannula with the equipment trolley blocking the doorway behind the patient's bed. Visitors to the department were squeezing through the gap until the staff member asked people to wait. These patients in corridors having cannulas inserted included those being inserted with ultrasound guidance. This meant patients were also having ultrasound scanning done while in the corridors.

Staff carried out daily safety checks of specialist equipment. We looked at two resuscitation trollies and their daily check logs. We found one check log had two gaps and the other had three gaps over the past four weeks. Both trollies were secured with a tamper proof seal. Last time we inspected we raised concerns about resuscitation trollies having both adult and paediatric equipment. Both trollies we checked on this inspection

had only adult equipment on them and the paediatric equipment was available in the department on a dedicated trolley. We checked eight sterile items these were all in date and sealed.

The two resuscitation trollies we looked at had airway and breathing equipment in the same draw. We noted that items that should be stored straight had been bent to fit them into this draw, including bougies. Bougies are long plastic sticks with a shape to aid the insertion of breathing tubes during some patient resuscitations. This meant in an emergency there was a risk equipment would not work as it should.

The department did not have suitable facilities to care for patients with mental ill health. The department's dedicated mental health room had three ligature points in this room. We pointed these out to the management, and they told us these were the emergency alarm buttons and that they had an approved plan to have these replaced with an alarm bar around the room. This room had suitable furniture that was comfortable and difficult to move in line with national guidance. The room itself was small and felt cramped, which would not be idea for patients having a mental health crisis. There were two toilets used by patients with mental ill health. Both of these had ligature points in them. Managers told us they would reduce the risk of self-harm by removing items that patients could use to create a ligature.

The service had facilities to meet the needs of patients' families although these were not always available. The department had a relative's room with couches, a table and some small decorative items to make the room feel less clinical. However, this room was also used for patient care. Staff told us this room was used for patients with mental ill health. While we were on inspection, we saw the room was used to treat several patients at once from the major assessment area including patients on intravenous fluids. This room had no ligature points on the walls but the furniture in this room was light and easy to reposition so could have been used to self-harm or as a ligature point.

The service had enough equipment to help them to safely care for patients. Staff reported having the equipment they needed. The therapy team told us they had access to all the equipment they needed to complete all their assessments. They also said they had access to more facilities such as a gym and a full flight of stairs in other part of the hospital if these were needed.

Generally, hazardous substances were stored securely. However, we found on our inspection one store cupboard containing cleaning tablets that was unlocked. This cupboard was in the sluice room with an unlocked door.

Staff disposed of clinical waste safely. The service had an up to date policy on disposal of waste. We check six bins which had foot pedal operated lids and waste was segregated correctly in line with national guidance. Waste bags were clearly labelled and stored in a secure room until collected for disposal.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient, remove or minimise risks, or update assessments. Staff did not always identify and act upon patients at risk of deterioration.

Staff did not always fully understand the triage process and staff did not always use the results to prioritise patients. Staff told us they found if difficult as some staff used a number system 1, 2, 3, and 4, and other staff told us they used a red, amber and green system. Managers told us that these two systems were meant to be used together but from our conversations with staff this was not clearly understood. Staff from the rapid assessment and treatment area told us they see patients in the order they arrived in the department and did not use the triage scoring to prioritise their workload. This meant that those patients with the most urgent needs were waiting while others with less urgent needs were seen that arrived before them. The service had a triage pathway that showed staff how to prioritise patients. This included a clinical risk assessment based on patients current national early warning score and had three categories; scores of less than four "low risk" coloured green, score of four to six "medium risk" coloured amber, scores of more than seven "high risk" coloured red.

Patients who made their own way to the department were not always assessed in a timely way to allow staff to assess their risks. These patients were first seen in the triage room and directed to major assessment area or the urgent care centre (UCC) for minor injuries or minor illnesses. The triage was staffed 9am to 4pm by a nurse

and a doctor. Outside of these times a nurse staffed the triage. While a doctor was present waiting times for the triage service were under 15 minutes but when they were not present the waiting time increased. When we visited in the evening the waiting time for triage was 40 minutes when the target is 15 minutes.

The department had a nationally recognised tool to identify patients at risk of deterioration and guide staff on how to escalate them. National early warning scores (NEWS2) were used for adults and paediatric early warning scores (PEWS) for children. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was commenced.

Not all staff used these tools to identify deteriorating patients and escalate them correctly. In all six paediatric patient records we looked at PEWS was calculated correctly, and action taken in line with trust policy. However, in the nine adult patients record we looked at NEWS2 was calculated and recorded correctly in three. This led to lack of escalation of patients when they needed to be. We saw to examples of patients that had not received treatment as quickly as they could have done if their NEWS2 score had been calculated correctly and action taken in line with trust policy.

The department carried out audits of compliance with NEWS2 completion. We looked at the results from January 2020 which showed 87% had a score completed and that all of these were calculated correctly. This audit had been recently introduction and managers planned for this to be integrated into their ongoing deteriorating patient audit.

We looked at the recording tool used by staff in triaging patients as they arrived and found that although a set of clinical observations were recorded there was no prompt to calculate a NEWS2 score. We looked at records showing delays in identifying unwell patients that needed rapid treatment. We identified patients that had not having observations done in line with the Royal College of Physicians guidance (2017) “national early warning score (NEWS) 2; standardising the assessment of acute-illness severity in the NHS”.

The department did not have consistent access to resuscitation equipment. We saw in the ambulatory care unit there was not enough space for a resuscitation trolley and staff as they had put five beds in the space for four chairs.

The department did not always manage sepsis in a way that kept people safe. Staff did not always carry out sepsis screens of patients when needed. There were no visual reminders of sepsis in the department. The trust had an up to date policy on sepsis management, but staff did not always follow this. We saw records that showed two patients had signs of sepsis that were not identified by staff for over three hours. Staff had an awareness of sepsis management. Mangers completed audits on sepsis treatment performance however, staff told us there was not any sepsis treatment audits showing staff were not aware of these being completed. However, we did see the department manage a paediatric patient with suspected sepsis in line with the trust’s policy including completing a septic screen.

Staff did not consistently complete risk assessments for each patient on arrival or update them when necessary using recognised tools. We looked at records of four older adult patients that had not had a fall risk assessment including one patient that had been in the department for over 12 hours. This meant staff had not assessed and recorded the risk of the patient’s having a fall while in the department. We reviewed the notes of four elderly, frail patients who had been in the department over six hours and found that none had a pressure area risk assessment completed. This meant the patients had not been assessed for risk of developing pressure ulcers and therefore these risk had not been reduced. However, we saw examples of patients with lower limb injuries receiving venous thrombus embolism risk assessment and given advice to reduce their risk.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). The psychiatric liaison service was present in the hospital from 8am until 11pm seven days. Outside of this time staff reported it was difficult to get support from the local crisis team.

The service had a mental health risk assessment to support staff in assessing and reducing risks for patients waiting for a psychiatric liaison assessment, staff carried out a. This assessment reminded staff about the rights of

patients under the Mental Capacity Act. This also prompted staff to think about reasons for patients to present as confused such as urine retention, dehydrations and infection. The assessment had a simple colour coded risk tool that had tick boxes for staff to record current symptoms including; current attempt at self-harm, suicidal ideation, and anxiety. There was a clear layout with four categories of risk; red, amber, yellow and green. Each of these risk levels had management advice to guide the immediate response from staff until a mental health expert can review the patient and provide a care plan. The risk assessment tool also had a list of useful contact details for staff to gain additional support.

The department had staff trained in safe restraint and conflict management. The departments mental health support workers were trained in safe restraint and most staff were up to date with their training. There were eight additional emergency department staff that although not mandatory had also completed safe restraint training. The department also had access to security staff that assisted medical staff with restraint when clinically indicated. We saw that security staff were available through the day in the emergency department. Security staff had licences from the Security Industry Authority with training in safe restraint and conflict resolution. The trust told us that their human resources team checked security staff's names against the Security Industry Authority register. These security staff were supplied via a service level agreement with a private provider. However, safe restraint training was not part of the trust's mandatory training for all emergency department staff.

Nurse staffing

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

The service had high rates of bank and agency nurses. Over the past 12 months the departments agency staff rate was 38% and the bank usage rate was 6%. Rates of usage of bank and agency staff were stable over this 12-month period. Manager told us they tried to use regular agency staff, so they were familiar with the department and trust's policies. New agency staff were given an induction to the unit. Staff said some agency staff had worked regularly for the unit and were like part of the team. Managers also told us they had worked to encouraged regular agency staff to apply for permanent posts in the department and had been successful. We spoke with a new member of staff that had previously worked for an agency in the department.

The number of nurses and healthcare assistants matched the planned numbers. On inspection we saw staffing numbers matched those planned by managers. However, due to the number of patients in the department they did not have enough nursing and support staff to keep patients safe.

The service had a rate 5.5% of unfilled shifts over the past 12 months. However, we had concerns about the number of staff planned on shift in relation to the number of patients. When we inspected the service had more patients to nurses than national guidance says is safe.

The ward manager tried to adjust staffing levels daily according to the needs of patients, but this did not work. The service had a "ghost rota" of staff that were available to support the emergency department when they had a surge in patients however, for the two days we inspected we did not see enough staff to the number of patients. Managers told us the "ghost rota" did not work and that when they request more staff from across the hospital this support was not given. Managers and staff in the emergency department felt that they were left to deal with pressure within the department without the support from across the hospital.

The trust used the Telford (1979) model to assess their nursing staffing levels for the emergency department. This model was based on the use of professional judgement to decide how many nursing staff were needed. National guidance is to use a professional judgement model and an acuity model together to assess minimum nursing staffing. The trust was not using an acuity model at the time of inspection.

The service did not always meet national guidance on minimum staffing levels from the Royal College of Emergency Medicine. The guidance for the lowest level of acuity of patients was one nurse to every 3.5 low dependency patients.

Staffing levels for the department was 14 nurses. This included one nurse in charge of the department, one nurse in charge of the major's assessment area with two more nurses supporting them, one nurse in charge of the rapid assessment and treatment area with two more nurse supporting them, four nurses in the major's cubical area, two nurses in the resuscitation area, and one nurse for the triage service.

In the rapid assessment and treatment (RAT) area we saw while on inspection that this area had the three nurses that were planned to be in this area. However, they had over the number of patients that should be being cared for by this area. The rapid assessment and treatment area were designed for eight patients on trolleys but on our arrival, we counted 14 patients being looked after in this area by three nurses. This equates to one nurse for every 4.7 patients which did not meet the Royal College of Emergency Medicine guidance.

During our visit the number of patients in the department increased and the department did escalate this and were given a small number of additional staff. Staff told us they had been given an additional nurse in the RAT area however now had 25 patients to care for. This was four nurses for 25 patients at a ratio of one nurse to 6.25 patients. The senior management were seen to be supporting patients and staff during a peak in demand across the department. Staff told us they were struggling to cope with the number of patients under their care. The number of patients in the department was not atypical the days we inspected.

The department did not always carry out safe staffing reviews. The two days we were on site the department did not carry out any safe staffing reviews. We highlighted this to the trust, and they have drafted a safe staffing tool for the nurse in charge to risk rate the current staffing level in the department. They also took immediate action to include staffing discussions at every board round lead by the nurse in charge of the department.

The department was not able to staff safely for the number of predicted patients. We also looked at the trust's predicted number of patients to attend the emergency department in a day verse the number of actual attendances. On the 4 March there were less attendances than predicted and we counted 16 patients being looked after by three nurses in the rapid assessment and treatment area. This was a ratio of one nurse to 5.3 patients.

Since we inspected, we asked the trust to provide us with daily staffing to patient ratios and these have showed similar staffing ratios for the first few days. However, the staffing ratios did improve greatly after this as the number of patients in the department reduced greatly. At this time there was a national effort in relation to a world pandemic and this may have had some effect on the number of patients in the department.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep patients safe. During our inspection, we did not see a shortage of medical staff. We saw medical staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Due to a lower number of consultants in the department managers had organised the medical workforce to consist of a larger proportion of more experienced junior medical staff that needed less support. The department had ten positions for consultants but when we visited there were only six in post. Managers had rearranged the schedule for cover so that each consultant had support during the week but at weekends there was only one consultant. Staff told us this model was working but they would benefit from being fully staffed. The service had a consultant lead for paediatrics that was qualified in paediatric emergency medicine.

The service always had support for junior medical staff from a constant. Monday to Friday consultants worked three shifts with one consultant on each. These were 8am to 5pm, 9am to 6pm, and 3pm to 10pm. The consultant

on the 3pm to 10pm shift also covered the on call until the next day. At the weekend one consultant attended the unit for a 9am to 5pm shift both Saturday and Sunday and covered the on call until the Monday morning.

The medical staff matched the planned number. We looked at the past four weeks of consultant rotas and found that all shifts had been filled as planned. The department had 5.7% of medical staff hours on the department were not covered.

The service had a stable vacancy rates for medical staff. We saw over the past 12 months there had been little change in the number of consultant vacancies and there had been changes in the vacancy rate for other medical staff, but this appear to fluctuate around the same level through this period. Managers told us they had recently been looking at new ways of attracting more medical staff to the trust. Managers and staff told us this had been working and the service had been successful in recruiting more middle grade doctors. These incentives included offering part clinical and part research positions. However, we saw on inspection that there was often two or more hours for patients to see a doctor.

Sickness rates for medical staff were low. Over the past 12 months the sickness rate for medical staff was 1.6%.

Managers could access locums and bank staff when they needed additional medical staff. Medical bank staff usage was 15.4% over the last 12 months and locum rates were 10.5% over the past 12 months. We saw over the past 12 months the departments usage of locum staff had reduced.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely. Staff could not always easily access records.

Staff could not always easily access records. The department used several different electronic systems to record medical information, also paper records were still used for some aspects of medical records. We saw staff had to record the same information in several places to ensure all staff knew the latest information. This included medical staff having to write up their assessments and reviews on an electronic system and a paper record. Staff told us the spent a large amount of time checking records and recording their actions. This meant staff had less time to spend with patients. Managers told us they had plans to introduce a new electronic records system that would condense several of their records systems into this one new system.

Staff did not always keep complete patient records. Some staff also told us that at busy periods due to the length of time to record their actions not all actions were being recorded. The department had recently introduced a new electronic system for recording observations. Staff told us they were not given sufficient training to use this technology effectively. Staff told us they could not always input observations as this took too long. This created a risk that staff would not identify deteriorating patients as basic documentation was not being completed.

Not all patient records were comprehensive. We looked at nine adult patient records and found that risk assessments had not been completed in two of these. We also found that three of these patient records had no observations recorded. We looked at six paediatric records that were completed comprehensively.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw staff were repeating information in several places that when handing over patients the new team were able to access the patients records in the format that the receiving team were accustom too.

Records were stored securely. Patient records were mostly stored digitally. These records were secured with access only granted to clinical staff via their smart cards. The paper records that including medicine charts were not stored in a secure area but were clearly visible to clinical staff at all times.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed three medicines charts of patients recently transferred from the emergency department to the medical assessment unit (MAU) One out of the three patients' medicines charts indicated a delay in the administration of intravenous fluids for

hydration. MAU staff told us it was not unusual to identify incomplete records and not be able to clarify, if medicines or intravenous fluids were administered or not. We also observed that while a label with patient identifiers was on the front of the medicines chart the label or patients name was often missing from the back page of the medicines chart used to prescribe and record the administration of intravenous fluids. Thus, increasing the risk of administering fluids to the wrong patient. We also reviewed three medicines charts of patients transferred from the emergency department to the surgical assessment unit (SAU). While these were complete, staff told us they frequently contacted doctors from the admitting team to prescribe the regular medicines. Therefore, we were not assured that all fluids and regular medicines were prescribed and administered in a timely manner or to the correct patient.

Staff did not always store and managed medicines and prescribing documents in line with the trust's policy. The pharmacy team visited the emergency department to check stock levels and order medicines from pharmacy. Nursing staff put the medicines received in the relevant cupboards and update relevant records for example pre-labelled medicines for supply on discharge. However, staff told us due to the workload the receipt records were not always completed, and the pharmacy staff would have to unpack the previous delivery before raising the next order. Therefore, there was a risk that while medicines may be in the department they may not be where the staff would expect to find them in an emergency.

Within the resuscitation area piped medical air was available within each bay, however only one of the six outlets were capped, potentially allowing air to be administered when oxygen is prescribed. Medical gas cylinders were stored in a dedicated room when not in use. The room lacked suitable signs and racking to ensure the separation of empty from full cylinders by gas type. Combustible materials were also being stored with the medical gases.

Prescription pads were stored securely. However, the records were not maintained in such a way to identify missing prescriptions. When we reviewed the records, we identified two prescriptions from the current prescription pad were unaccounted for. Therefore, we were not assured the unaccounted-for prescriptions would be identified.

Staff did not always follow current national practice to check patients had the correct medicines. Triage nurses and other emergency department staff explained how they identified and clarified the medicines patients were taking before their attendance at the emergency department. Pharmacists based in the medical assessment unit visited the emergency department Monday to Friday to provide pharmaceutical advice to the clinical and nursing staff. However, pharmacy staff we spoke with were concerned that they were not always able to review all patients, where the decision to admit had been made and the patient remained in the emergency department waiting to be transferred to a ward. Thus, reducing the opportunity to undertake medicines reconciliation within 24 hours of admission. Therefore, we were not assured that processes were in place to ensure patients received the correct medicines in a timely manner.

Incidents

Staff recognised and reported incidents however, managers asked staff not to report repeat incidents. Managers investigated incidents. Managers did not always identify learning from incidents. However, learning from incidents was not shared with staff. Incidents were not graded in line with the trust policy.

Staff knew what incidents to report and how to report them but did not always report them. Staff told us they had reported incidents but that when reporting incidents that were ongoing issues staff were told by managers to stop reporting these. This included staffing levels and patients with needs different to the area they were in such as patient remaining in the observation bay for longer than 24 hours. This created a risk that incidents were not report and therefore no learning was gained from them to prevent reoccurrence. Staff told us they had reported incidents on the trust intranet via an online form.

Requires improvement

Urgent and emergency services

Staff raised concerns and reported incidents in line with trust policy. We looked at four incidents with all four having enough detail to understand the nature of the incident.

Staff did not grade incidents in line with trust policy. The four incidents we looked at three were incorrectly graded and one was graded correctly. The three incidents that were incorrectly graded were all graded lower than the trust's policy shows they should have been.

Staff were not involved in the investigation of incidents. Three of the four incidents we reviewed had no record of involvement of staff in the investigation process. The fourth was still under investigation and was involving other staff in the investigation as this was going through a full route course analysis. Staff we spoke with told us after they reported incidents they did not hear about the investigation until it had been completed.

Managers investigated incidents and recorded most of these investigations. Three of the four incidents we looked at had evidence of investigations being carried out but only two had detailed records of how these investigations had been completed. The fourth had no evidence that it had been investigated.

Managers did not always identified learning from incidents. Two of the four incidents we looked at had no learning identified. One incident that was reporting concerns about staffing skill mix identified long term learning that the department needed to improve their recruitment of highly skilled staff. The last incident record we looked at showed a full route course analysis was still in progress but had identified an immediate action for staff to carry out self-reflection.

Managers did not routinely share learning from incidents with staff. The four incidents we looked at had no evidence of how any learning was shared with staff. Staff told us they sometimes got feedback about incidents that they personally reported but did not receive feedback about incidents reported by other people.

The service had no never events in the department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Safety Thermometer

The service used monitoring results to improve safety. Staff collected safety information and made it publicly available.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

The patient safety thermometer showed between March 2019 and February 2020 the trust achieved an average of 92% harm free care. Harm free care is considered all patients that received care without having a fall, acquiring a pressure ulcer grade 2 or above, acquiring venous thrombus embolism (a blood clot normally in the leg or lung), or acquiring a urinary track infection with a urinary catheter.

(Source: NHS Digital - Safety Thermometer)

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Our rating of effective stayed the same. We rated it as **Requires improvement.**

Evidence-based care and treatment

Staff did not always follow the department's policies. The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.

Staff protected the rights of patients' subject to the Mental Health Act and followed the Code of Practice. The

trust had an up to date policy for mental health care, mental capacity assessments, and deprivation of liberty standards. Staff were aware of these policies and knew where to find them.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. The policies were easily found on the trust intranet and staff were able to show us how they accessed them. Agency staff were also able to access these policies.

The service did not review all policies regularly. We looked at five policies which followed best practice and national guidance however, only one was in date the other four had not been reviewed in a timely way. Two of these had not been reviewed by the date specified on the policies. The other two had no review date listed and had not been reviewed in the past 12 months so we were not assured that these policies were being regularly reviewed.

Managers and staff completed audits based on the trust policies to check that all staff were compliant with the guidance. These audits included falls risk assessment, venous thrombosis assessment, and hand hygiene.

We looked at four standard operating procedures which were all up to date and followed national guidelines and best practice. However, we saw managers and staff were not following the full capacity standard operating procedure during our inspection. We also saw staff were not always following the trust's triage pathway.

Nutrition and hydration

Patients were not always given the support needed to eat and drink. However, patients were given food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients told us they were offered a choice of food during their stay. We were told staff had asked patients if they had any food allergies or dietary requirements before offering a choice. We saw patients having intravenous fluid given when needed.

We saw patients were not always given the support needed to eat and drink. We saw patients did not have tables to put their food and drink on that caused patients to have to put food trays on their legs while eating.

The main waiting area had a vending machine for snacks, and soft drinks, with a separate hot drinks machine and water dispenser. Patients and relatives in the rapid assessment and treatment area had a kitchen area where they could make drinks. However, patients waiting in the major's assessment area did not have access to vending machines.

Pain relief

Staff did not always record patients pain scores. Some patients did not receive pain relief in a timely way. However, staff assessed and monitored patient's regularly to see if they were in pain.

Patients received pain relief soon after requesting it. We saw adults and children being given pain relief soon after requesting it. Patients told us their pain was being managed well.

Staff were assessing paediatric patients' pain using a recognised tool. We saw in the six paediatric patient records we reviewed three had pain scores recorded and the other three records show that the presenting complaint would not have initiated a pain score being completed.

Staff did not always assess adult patients' pain using a recognised tool which could result in patients being in pain longer. We looked at 11 adult patient records and in nine there was no pain score recorded. However, we saw nursing staff asking patients about their pain and most patients told us staff had asked them to describe the level of pain they were experiencing using a scale of one to ten. Staff told us they did not always record pain scores on the electronic monitoring system as they were not prompted to input this when completing observations.

Patients did not always receive pain relief in a timely way. We saw staff that triaged patients as they arrived in the department assessed patients' pain and gave them pain relief when needed. However, in the evening when the waiting time for triage was over 45 minutes patients were having to wait until they were seen to be given any pain relief.

Patient outcomes

Staff did not always use monitoring information to assess and improve effectiveness of care and treatment. They used findings to make improvements.

The service participated in all relevant national clinical audits and managers carried out a comprehensive audit programme. The trust had just participated in the new Royal College of Emergency Medicine audits which was waiting to be published. One consultant took the lead on audits to ensure that they were completed.

Managers shared and made sure staff understood information from the audits. Staff told us they received feedback about audit results from their managers at team meetings.

Managers involved junior staff in audits. Junior staff told us they were given an audit to complete and monitor the performance. These audits included; hand hygiene, falls risk assessment, and cleaning assessment.

Improvements were made because of audit findings. The recent hand hygiene audit had identified issues with staff compliance with trust policy. Managers arranged that at the next team days they would use an ultra violet light box to practice good hand hygiene.

The department submitted information to national audits completed by the Royal College of Emergency Medicine. The department used the results of these audits to produce action plans to improve areas of concern identified in these audits. However, one audit, that we would expect to be completed annually had not been completed from 2017 until March 2020. The lay out of this audit did not make it clear if the department had improved against the results of the previous audit. The Royal College of Emergency Medicine completed a consultant sign off audit in 2016/2017 which found the department did not meet any of the national standards. The department managers created an action plan to improve the service however, the department did not conduct a repeat of this audit so they could not be assured as to the effectiveness of these improvement.

Trauma Audit and Research Network (TARN)

The Trauma Audit and Research Network (TARN) audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults). The audit had five measures with four of these having targets and four being compared to the national average for this audit. The department met three of the four targets and the final target they met some of the time. The department was worse than the national average for two of the measures, was as expected for one and was better than the national average for one measure. The results for 2018 audit are below;

Case ascertainment, the departments performance was 70.1% to 82.6% compared to the standard of 80%. (Proportion of eligible cases reported to TARN compared against hospital episode statistics data.)

Crude median time from arrival to computer tomography (CT) scan of the head for patients with traumatic brain injury, the departments performance was 59 minutes compared to the standard of 60 minutes, and the national average for this audit at 31 minutes. (Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allow treatment which minimises further brain injury.)

Crude proportion of eligible patients receiving tranexamic acid within 3 hours of injury, the departments performance was 100% compared with national average for this audit of 78.5%. (Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding.)

Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care, the departments performance was 0% compared with the national average for this audit of 32%. There was also an aspirational national standard of 100%. TARN acknowledges that this standard is challenging for services to meet. (Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by suitably trained specialists.)

Risk-adjusted in-hospital survival rate following injury, the departments performance showed 2.2 additional survivors, compared to the standard of no additional deaths and the national average for this audit of zero

additional deaths. (This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)

(Source: TARN)

Unplanned re-attendance rate within seven days

The service had a higher than expected risk of re-attendance than the England average.

From December 2018 to November 2019, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.

December 2018, trust performance was 10.0% compared to an England average of 8.1%.

January 2019, trust performance was 10.0% compared to an England average of 8.0%.

February 2019, trust performance was 10.0% compared to an England average of 8.0%.

March 2019, trust performance was 10.0% compared to an England average of 7.9%.

April 2019, trust performance was 11.0% compared to an England average of 8.3%.

May 2019, trust performance was 11.0% compared to an England average of 8.4%.

June 2019, trust performance was 10.0% compared to an England average of 8.2%.

July 2019, trust performance was 10.0% compared to an England average of 8.2%.

August 2019, trust performance was 10.0% compared to an England average of 8.3%.

September 2019, trust performance was 10.0% compared to an England average of 8.3%.

October 2019, trust performance was 10.0% compared to an England average of 8.3%.

November 2019, trust performance was 10.0% compared to an England average of 8.3%.

(Source: NHS Digital - A&E quality indicators)

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff told us they attended conferences and had been asked to present case studies at these events.

Staff had opportunities to improve their knowledge and skills. The department had link nurses for different areas of special interest including; moving and handling, infection prevention and control, and falls. These link nurses attended additional training in their specialist area which allowed them to provide formal and informal training sessions to staff in the department. This included providing easer access to face to face moving and handling training sessions to keep staff up-to-date with trust guidance.

The service had developed team days which all staff attended once every six weeks. Staff told us these involved training and going through updates to guidance.

Staff received training on mental health conditions. The department had worked with the psychiatric liaison team to create a training program for the department staff to gain a better understanding of mental ill health and how to support patients. This was made up of three levels of training with level one offered to all staff, level two offered to registered nurses, and level three offered to those staff identified by the trust as needing a greater understanding of mental health. This was a new training program and at the time of inspection 28 staff had completed this training.

Managers gave new staff a full induction tailored to their role before they started work. All registered nursing staff we spoke with told us they had been given a full induction and time supernumerary to adjust to the department. They told us this supernumerary time was tailored to each person so that they received what they and their manager felt was enough time for them. The induction program incorporated hand hygiene, use and storage of hazardous cleaning products, use of personal protective equipment and safe use of sharps.

Managers supported staff to develop through supportive clinical supervision of their work. We saw medical staff being supervised and supported by their seniors. Nursing

staff told us the department's practice development nurse supported them. However, nursing staff told us they felt that the department needed more than one practice development nurse to be able to provide support for all the nursing staff in the department.

Managers supported most staff to develop through yearly, constructive appraisals of their work. However, the service only met their target of 85% in one staff group. The service had appraisal compliance rates of 100% for medical staff, 70% for nursing staff, 67% for none registered clinical staff, and 65% for administrative staff.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. The department had a therapy team that supported rapid discharges from the emergency department which included; occupational therapists, physiotherapists, discharge managers and therapy assistants. This team worked with staff from the social care sector to arrange care packages to start the same day. Staff spoke highly of the positive culture of working together to safely discharge patients and preventing unnecessary admissions to hospital wards.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff told us they had a good joint approach to supporting patients with mental ill health working with the local mental health services. The trust had a psychiatric liaison service present in the hospital from 8am until 10pm and out of these hours had access to the crisis team. The psychiatric liaison staff said the emergency department staff efficiently identified people that benefited from their support and produced high quality referrals. The department also had recruited mental health support workers so that there was always one of these support workers in the department to immediately support these patients.

The emergency department staff worked well with speciality teams from across the hospital. We saw emergency department staff discussing patients with speciality teams. Patients were seen by a frailty team when needed. We saw the frailty team had seen patients in the emergency department which was led by a consultant specialist for frailty medicine.

Staff in the department worked well together and with some teams from across the hospital. Staff told us the security staff were quick to respond when they needed them and always try to support the clinical staff. We saw security staff respond to the emergency department to support staff and to keep a safe patient. We saw medical and nursing staff communicating in an effective and positive way.

However, some nursing staff from across the hospital did not work well with the department. Nursing staff in the emergency department told us they felt the hospital ward staff did not appreciate the pressures on the department. We spoke with two nursing mangers from other parts of the hospital that told us they were not under much pressure on their wards. This was while to emergency department had patients waiting over 10 hours for beds on wards.

Seven-day services

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

The emergency department was open and provided care to adults and children 24 hours a day, 365 days a year. The paediatric section of the department was open 24 hours a day which was an improvement from the last time we inspected.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services 24 hours a day, seven days a week. There was a consultant present in the department from 8am until 10pm for Monday to Friday and from 9am to 5pm on the weekends. Outside this time there was a consultant on call to support medical staff overnight. There was a therapy team in the department seven days a week from 8am to 6pm.

The department had access to a range of diagnostic imaging services, in line with National Health Service seven days a week priority clinical standard five. This includes x-ray and computerised tomography.

There was a psychiatric liaison service present in the department from 8am until 11pm seven days a week.

Outside of these times there was a crisis team available by phone referral system and then they would come to support with the mental health patient assessments. The department also had a mental health support worker present 24 hours a day seven days a week.

Health promotion

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

Staff informed us clinical information leaflets were available electronically and that they would be printed for patients on a case by case basis. This included information leaflets about the risks associated with reduced mobility after having a lower limb injury. We saw in one of the patients records we looked at that this had been given along with verbal advice was given to a patient being discharged after having a lower limb fracture immobilised with a cast.

We saw information leaflets to help support patients manage their own health. Leaflets we saw covered a variety of different injuries including burns, pulled elbow, head injuries and sprains. There were leaflets in children's emergency department specific to children for example pulled elbow (child). The leaflets for managing health conditions also contain health promotion information. In the pulled elbow (child) leaflet there was a page highlighting the national program "five a day" encouraging people to eat more fruit and vegetables, and a page that explained the link between parents that smoke influencing their children to smoke. Staff told us they would also discuss the importance of healthy lifestyles while they were being discharged.

The service had posters promoting physical and mental wellness. The entrance to the department for walk-in patients had a poster promoting patient's health during their hospital stay. The poster covered a variety of topics that would help kept patients safe during their stay. This included information on how to prevent; falls, blood clots and pressure ulcers. We saw information posters for patients on how to access emotional support and guidance. This included in the main reception area there was information about mental health support available for children and young people, and sign posting support for those at risk of domestic abuse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service did not ensure all staff completed training. However, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had an up-to-date policy on mental capacity and consent that had been reviewed in the past 12 months. This policy followed national guidance and described how staff would use this in practice.

Not all staff received or kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Nursing staff compliance with this training was 83% and medical staff compliance was 59% which were both below the trust's target of 85%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff described to us the principle of these acts including the principle of providing all reasonable support for patients to make their own decisions whenever possible.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to describe in line with the national guidance the process of accessing patient's mental capacity and knew when they would need to carry out this assessment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw staff confirming consent with patients before performing diagnostic tests or providing treatment.

Are urgent and emergency services caring?

Good

Our rating of caring improved. We rated it as **Good.**

Compassionate care

Urgent and emergency services

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

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introducing themselves by name and role and interacted with patients in a friendly way. Patients told us most staff introduced themselves by name with one patient telling us they could name all the people who had look after them during their stay.

Patients said staff treated them well and with kindness. All patients and relatives we spoke with said staff care about them and staff were approachable. A patient told us staff were 'marvellous and caring'. Other patients said nurses in the department are 'friendly' and 'wonderful people'.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us patients with mental health needs were supported by the department's mental health support workers.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw staff checking with patients what their normal state was to them.

Staff tried to be discreet and responsive when caring for patients however, the privacy of patients was not always achieved due to the lack of space in the department. We saw staff pulling curtains around when performing intimate care to protect patient's dignity.

Staff did not always maintain patient's dignity in the department. Staff told us they tried to maintain privacy and dignity of patients in rapid assessment and treatment (RAT) during busy periods. During these busy periods there were patients being care for in the corridors of the department. Staff told us they tried to keep a bay free in the RAT area so patients could be moved in there if they needed to use a commode or have private conversations. We did see though that some intimate conversations were carried out in the corridors. Patients also told us staff had conversations about their care in the corridors. Managers told us staff used mobile screens when needed to protect the dignity of those patients being care for in the corridors. On the first day of our inspection screens were not being used in the corridors. However, on the second day they were.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust's accident and emergency departments scored between 77.5% and 84.2% from October 2018 to September 2019.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed. Patients told us they knew how to seek help and staff would listen to their needs. A patient told us how they were feeling worried that they were not receiving the right medicine. They went on to tell us about how a nurse took the time to talk with them, so they understood their treatment and provided them with emotional support.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw patients being cared for in corridors. We saw a patient living with dementia became confused about where they were. Staff took time with the patient to comfort them. Staff also move the patient to a bay in majors to provide a calmer environment for the patient.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A patient told us how being in resus was an emotional experience and the staff had been 'incredible' in their support and care. One relative told us they appreciated being offered food and drink. The relative told us they would have worried if they left the patient, and the refreshments allowed them to remain at the bedside.

Understanding and involvement of patients and those close to them

Requires improvement

Urgent and emergency services

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

Staff made sure that patients and those close to them understood their care and treatment. Patients we spoke with said with staff kept them informed of what was happening during their stay. We observed staff explaining what tests they would like to conduct and took the time to explain and answer questions from the patient and relative.

Patients gave positive feedback about the service. A patient described staff as 'electric' meaning the team was well organised team and meeting their needs efficiently.

Staff talked with patients, families and carers in a way they could understand. One relative told us staff had checked on their well-being as the patient was sleeping. They felt staff cared for them and the other patients exceptionally well and commented 'I don't know how they coped last night [there had been a high number of patients in department overnight], absolutely extraordinary, fantastic staff'. Another relative told us staff were 'out of this world'.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that did not always meet the needs of local people and the communities served. Services were not always planned in conjunction with other local services.

The department did not have enough space for patients to wait for treatment. The department had a main reception area with a waiting area that had chairs and vending machines. We saw during the day there was sometimes enough space for all patients to have a seat but other times they would have to stand until a seat became free. At night we saw this area was crowded with people sitting on the floor and standing in the spaces between the chairs. This was the space used for patients to wait for booking into reception and to them wait for streaming.

The department did not have enough space for the treatment and care of the local population. The department design had not kept pace with the increase in local population. However, the service had plans to increase their capacity with work due to begin in April 2020.

The department had a streaming room that allowed patients to be assessed privately. Patients that were assessed to be 'fit to sit' were streamed to the urgent care centre. The urgent care centre had three consultation rooms for the emergency nurse practitioners to see patients for minor injuries and one room that a GP used to see patients for minor illness. The GP service was organised by the department via a service level agreement with another provider. One of the consultation rooms was set up for eye examinations. This area had a dedicated waiting area for their patients. All times we visited this area there was enough space for patients and relatives to sit. The GP service was available from 8am until 8pm and the emergency nurse practitioners were present from 7:30am until midnight.

The emergency department used the following areas for patient treatment; resus, majors, majors assessment, rapid assessment and treatment, and the corridors around these areas. The department also had an observation area and an ambulatory care unit. These areas were open 24 hours a day seven days a week and served the area of south east Kent around Ashford. The hospital had a hyper acute stroke unit that admitted patients from across the region for treatment of stroke. The hospital also carried out primary percutaneous coronary intervention so admitted patients that met the criteria from across the region for this treatment.

The department had mental health support workers to support patients. Staff reported these support workers helped patients. However, staff also noted some patients found their uniforms distressing as they currently wore plain white tops that for some patients were associated with staff from historic mental health asylums.

The department had a relative's room, but this room was not always accessible for relatives. This room had soft

seating, tables and some small decorative items that made the room feel less clinical for relatives. We saw on our visit that this room was used for patients and their families to wait for assessment or treatment. Staff told us this room was also used for mental health patients when the dedicated mental health room was already in use by another mental health patient.

Staff could access emergency mental health support seven days a week for patients with mental ill health but was not consistently available 24 hours a day. The emergency department had a protocol in place to trigger a referral to the psychiatric liaison team once a mental health need had been identified. The psychiatric liaison team generally responded within the hour and completed a detailed assessment of the patient's needs. The psychiatric liaison service was present in the hospital from 8am until 11pm seven days a week. Staff reported while the psychiatric liaison service was present in the hospital this worked well but that outside this time, they relied on the local crisis team. Staff said this resulted in patients often having to wait until the psychiatric liaison service came in the next day.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. The service coordinated care with other services and providers.

The department was not designed to meet the privacy needs of patients. We saw patients were having to be moved in and out of cubicles for intimate care. This caused a constant movement of patients around the department with patients being moved out of cubicles to corridors. We saw ambulance crews and their patients were having to queue in any space in the corridors around emergency department patients and in the entrance corridor. Due to the short supply of private space in the department this was used for the most intimate care and treatment meaning that other care that would normally be done privately was being carried out in corridors. This included; doctors discussing treatment with patients, intravenous therapy, and intravenous cannulation. There was no information displayed in the department to highlight their policy on chaperoning including their being no signs in waiting areas or the department reception area.

However, the service had tried to make some improvements to meeting patient's privacy needs. We saw posters throughout the department informing patients and visitors to protect the privacy and dignity of patients by not filming or taking pictures, without talking to a member of staff. Also, there was a poster informing visitors to be aware of 'tailgating'. This is when unknown people follow authorised people through secure access doors. Although, on our inspection we found that some doors were not kept secure in the department. This included the door from the reception area to the rest of the department that had an electromagnetic lock but was not functioning.

Some staff understood the needs of patients living with dementia. Staff had dementia training during their induction. Compliance with this training was much lower than the trust's target of 85%. Nursing staff compliance with this training was 40% and medical staff compliance was 8%.

The department met the needs of some patients living with dementia. Staff told us patients living with dementia would be supported by a one to one care support worker but that due to staffing levels this was not always possible. We saw a patient living with dementia that became distressed while being care for on a trolley in a corridor. Staff then moved this patient to a quieter space within the department. Although support was given to this patient, they were not being cared for in a suitable area at the time they became distressed.

Staff tried to meet the needs of people with learning disabilities. Staff told us they had with previous patients got beds for them instead of trolleys to give them more space to move around. Staff also told us they would try to move these patients to quieter areas of the department. On our inspection we saw there were two side rooms and that the rest of the department was overcrowded and noisy so we were not assured that they would be sufficient quiet space in the department for all patients that would need these.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was a hearing loop for the hearing impaired available within the emergency department.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us telephone interpreters could be accessed quickly for unannounced visitors. Staff were advised not to use family members or children to interpret but could use medical colleagues with additional languages if necessary.

The service supported bariatric patients needs. Staff told us the ambulance service would call ahead of arriving with a bariatric patient. Staff used this information to prepare to receive them, this included getting a bariatric bed to transfer the patient too on their arrival and a bariatric chair and commode.

The department worked with a private provider and the local authority to support rapid discharge from the emergency department without needing to be admitted to a ward. For patients that needed home assessments and minor adaptions these were organised by the departments therapy team working in collaboration with a private provider. This team also organised care packages for patients that were able to return home with support and did not need to remain in hospital. This was better for patients and the hospital as this reduced the number of patients being admitted for social care reasons.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. However,

Patients who arrived by ambulance or the Helicopter Emergency Medical Service (HEMS) were taken into the rapid assessment and treatment area (RAT) to be assessed. Some patients were referred by GPs or the 111 service. However, when we visited the department was overcrowded and this led to patients arriving by ambulance having to wait in the corridors. Ambulance staff told us this level of overcrowding, delay to handover and handover in corridors was common. Emergency department staff agreed that this number of patients in the department was normal.

Patients who made their own way to the department were first seen in the triage room and directed to the major's assessment area or the urgent care centre (UCC) for minor injuries or minor illnesses. The triage was staffed 9am to 4pm by a nurse and a doctor. Outside of these times a nurse staffed the triage. While a doctor was present, we saw the waiting times for the triage service were under 15 minutes but when they were not present the waiting times increased. When we visited in the evening the waiting time for triage was 40 minutes which is above the target of 15 minutes.

The service was working to improve their triage waiting time. The introduction of a doctor to the triage service was a trial for six months from October 2019 until March 2020. The five months that this trial had been operating showed compliance with patients having initial assessment within 15 minutes was between 92% and 96%. The five months before this trial started the compliance was between 68.3% and 85%.

There was insufficient contact between the reception staff booking patients in and the triage team. During our evening visit we saw a patient arrive that was clearly in pain and was bleeding heavily. This patient was advised about the 40-minute delay and asked to wait. We waited and saw no response to this patient from the triage team, so we intervened to highlight the immediate needs of this patient.

Children and young people who arrived at the adult's reception were seen in the paediatric assessment unit. This was opposite the main reception desk and was access by an intercom and a secure door that was opened by staff inside the paediatric assessment unit. If needed there was also a dedicated paediatric resuscitation bay. Staff told us this was never used for adult patients and while we were on inspection, we saw staff kept this bay for paediatric use only.

The service moved patients frequently within the department without a clear medical reason or in their best interest. We saw patients being cared for in corridors on both days we visited the department. This resulted in patients being moved in and out of cubicles for intimate

care and being moved to allow other patients access around the department. The corridors were narrow, and patients being cared for in corridors caused difficulties for staff and patients moving around the department. We saw relatives confused to come back to find their relative had been moved into a corridor.

The department had worked to reduce the time taken for patients to receive intravenous medication by having a dedicated intravenous access team for the emergency department. An audit we looked at showed this team had a 98% first time success rate of insertion of intravenous cannulas. Intravenous cannulas are required before patients can receive some common medications used in the emergency department.

Median time from arrival to treatment (all patients)

Managers monitored waiting times however not all patients could access emergency services when needed or receive treatment within agreed timeframes and national targets. There was a screen that displayed the estimated waiting time for the main reception area, but this was not clearly visible from all areas of the waiting area. The department had signs telling patients what treatment or assessment to expect in each area and how long patients should expect to wait. We noted that the sign for the triage area said patients should be seen within 20 minutes, but the national standard is for patients to be seen within 15 minutes, so this sign was misinforming patients.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for nine months over the 12-month period from December 2018 to November 2019. This had improved since our last inspection when the trust did not meet the one-hour standard for ten months from February 2017 to January 2018. From December 2018 to November 2019 the trust performed better than the national average for all twelve months.

- In December 2018 the median time to treatment was 52 minutes compared to the England average of 60 minutes.
- In January 2019 the median time to treatment was 49 minutes compared to the England average of 63 minutes.
- In February 2019 the median time to treatment was 53 minutes compared to the England average of 66 minutes.
- In March 2019 the median time to treatment was 59 minutes compared to the England average of 65 minutes.
- In April 2019 the median time to treatment was 61 minutes compared to the England average of 66 minutes.
- In May 2019 the median time to treatment was 57 minutes compared to the England average of 64 minutes.
- In June 2019 the median time to treatment was 59 minutes compared to the England average of 65 minutes.
- In July 2019 the median time to treatment was 58 minutes compared to the England average of 68 minutes.
- In August 2019 the median time to treatment was 59 minutes compared to the England average of 61 minutes.
- In September 2019 the median time to treatment was 62 minutes compared to the England average of 65 minutes.
- In October 2019 the median time to treatment was 57 minutes compared to the England average of 65 minutes.
- In November 2019 the median time to treatment was 65 minutes compared to the England average of 70 minutes.

(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours

Managers and staff did not make sure patients did not stay longer than expected. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From January 2019 to December 2019 the trust failed to meet the standard and performed worse than the England average. The percentage of patients admitted,

transferred or discharged within four hours within these dates varied from 74% to 81%. This had improved since our last inspection when from February 2017 to January 2018 the percentage varied from 70% to 80%.

(Source: NHS England - A&E Waiting times)

Managers monitored patient transfers and tried to follow national standards. Senior staff reported that the trust recognised that meeting the four-hour performance target was a challenge and a trust wide problem. They told us a new transformation team was looking at the flow of patients in and out of the department and the impact of this on the whole trust. A patient flow co-ordinator role had been developed and they were available 24 hours a day seven days a week. Staff reported that this allowed the nurse-in-charge to remain in a clinical role.

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From January 2019 to December 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was similar to the England average. The percentage of patients waiting more than 4 hours within these dates varied from 10% to 27%. This had improved since our last inspection when 50% of patients were waiting more than four hours to be admitted from the decision to admit.

(Source: NHS England - A&E SitReps)

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from January 2019 to December 2019, 36 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in November (15), December (12) and October (8). There were also eight months that no patients waited over 12 hours. This had improved since our last inspection when 587 patients had waited more than 12 hours between January 2018 to April 2018.

(Source: NHS England - A&E Waiting times)

Managers monitored patient transfers however the service did not meet national standards. The department had created a new post for a 'flow coordinator' to help the nurse in charge manage patient flow through the department. We saw this role provided essential support to the nurse in charge. However, the department still had large numbers of patients awaiting transfer to a ward. The first day of inspection we attended the evening bed meeting where managers briefly discussed each patient awaiting a bed and three patients had beds identified for them on medical wards, but this left 22 medical patients to spend the night in the emergency department. At this time these patients had been waiting for a ward bed for up to 10 hours. On the second day of our visit there was also overcrowding in the department.

The observation bay was for patients to stay for up to 24 hours, but staff reported that often patients spent longer than this in this area. On our visit we saw one patient in this area had been there for 61 hours and looking at the list of patients in this area showed the majority of patients had been there for more than 40 hours. Managers were aware of this and had plans to improve the emergency department capacity to help reduce the pressure on the observation ward.

We saw the resus bays were full and the ambulance service phoned to inform the department that they were bringing three adult patients that needed resus beds. The nurse in charge and the lead consultant worked together to manage the flow of three patients out of the resus area to create the space needed.

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

The number of patients leaving the service before being seen for treatments was higher than the national average. From December 2018 to November 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average. The month of February 2019 the figure shows 0.0% but this appears to be an error in the data.

In Dec-18 the percentage was 4.0%, compared to the England average which was 1.8%.

In Jan-19 the percentage was 4.0%, compared to the England average which was 1.8%.

In Feb-19 the percentage was 0.0%, compared to the England average which was 1.8%.

In Mar-19 the percentage was 4.0%, compared to the England average which was 2.4%.

In Apr-19 the percentage was 4.0%, compared to the England average which was 2.5%.

In May-19 the percentage was 3.0%, compared to the England average which was 2.4%.

In Jun-19 the percentage was 4.0%, compared to the England average which was 2.6%.

In Jul-19 the percentage was 4.0%, compared to the England average which was 2.7%.

In Aug-19 the percentage was 5.0%, compared to the England average which was 2.5%.

In Sep-19 the percentage was 4.0%, compared to the England average which was 2.4%.

In Oct-19 the percentage was 3.0%, compared to the England average which was 2.0%.

In Nov-19 the percentage was 3.0%, compared to the England average which was 2.2%.

(Source: NHS Digital - A&E quality indicators)

The percentage of patients leaving the department before being seen for treatment had increased from our last inspection. In our last report 2% of patient had left without being seen from January 2018 to April 2018.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff we spoke with told us they tried to discharge patients that did not require to be an inpatient. This included using the services of their therapy team that worked as a rapid discharge service for the emergency department. This team had physiotherapists, occupational therapists, discharge managers, and therapy assistants. Staff from this team reported they worked closely with social services. Nursing and medical staff identified patients that would have had to be admitted to a ward for social or therapy input but not a medical reason. These patients were referred to the therapy team for them to try to arrange the support needed for patients to be discharged the same day from the emergency department. This prevented keeping patients in hospital longer than needed.

Staff did not always plan patients' discharge carefully, particularly for those with complex mental health needs. We received many complaints about a lack of information given to patients on discharge. Staff told us they do not routinely provide written discharge information to patients as they provide this information verbally for patients. This was not always an effective method of communicating this information. From the complaints that we received this has resulted in additional reattendance to the department for some of these patients. This has also resulted in patients not following medical advice as they do not recall this information when they get home. While on inspection we saw a patient had been incorrectly discharged as the department staff thought they had left the department but were actually on a trolley in a corridor.

Learning from complaints and concerns

People were not easily able to raise complaints. Some patients were able to raises concerns. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Patients, relatives and carers did not know how to complain or raise concerns. Most patients we spoke with did not know how to make a complaint but told us they would raise concerns with a member of staff. Staff told us they would try to resolve the complaints locally first, if this was not possible this would be escalated to the nurse in charge.

The service did not clearly display information about how to raise a concern in patient areas. We saw no information in the emergency department about how to complain. Staff told us complaint leaflets were available at the emergency department reception. Administration staff in emergency department reception area were unable to provide a complaint leaflet and informed us the leaflets had not been available for a while. Staff were able to describe how they would deal with a complaint; staff told us they would always try to resolve any issues immediately. If issues could not be resolved staff would direct the complainant to the trust's website or patient advice and liaison service (PALS) located down the corridor.

The PALs office was not clearly signed posted. We checked a map of the hospital next to the emergency department which, did not show the PALS office on it. We asked at the main reception where PALs were found and

were told they were just behind the main hospital reception desk. The PALs team at the hospital was called the Patient Experience Team (PET) this was also not on the map.

At the hospital main reception, we looked at a complaints form and leaflet called 'talk to us'. The leaflet had information of how to make a complaint and had advice on the final stage of the complaints process being the Parliamentary and Health Service Ombudsman (PHSO). This meant patients and relatives knew whom to contact if they were not satisfied with the trust's response. These leaflets had signposting to an Independent advocacy service, to support those in need of an advocate during their hospital stay or through the complaints process.

Patients were able to report concerns and provided feedback about their care after leaving the department. Staff told us all patients were sent a feedback survey via text message to their mobile phone number registered when they arrived at the department. These text messages asked patients to rate the service out of five and to give any comments about their care. However, patients that did not use mobile phones would not be able to take part in this method of feedback.

Managers investigated complaints and identified themes. We looked at four complaints records and these had been investigated by looking at patient records, talking with staff and speaking with relatives. In one record we saw the managers had organised a family meeting to discuss their concerns. The responses for all four complaints showed learning identified and improvements taken. We looked at four complaints records and none had completed a response within the timeframe agreed in the trust's complaints policy. We looked at the minutes from three governance meetings showing complaint themes were discussed and actions identified to make improvement based on this feedback. This included putting up a poster to remind staff to remove intravenous cannular before discharging patients.

Managers were not always responding to complaints within the timeline set out in the trust's policy. The trust had two timelines for responses to complaints 30-days for complaints about one service and 45-days for complaints two or more services. We saw records showing managers had responded to three of 16 complaints within 30-days between December 2019 and January 2020. Managers had responded to eight of 12 complaints within the 45-day timeline between December 2019 and January 2020. Managers had identified they were not responding to complaints in a timely way and had acted to improve their response times. This included recruiting a new manager to support with gathering information and drafting responses.

The department informed complainants how to escalate their complaint if they were not content with the trust's response. We looked at four complaints responses which all had details on how to contact their named complaints handler within the trust's complaints team. They also all detailed how to raise a complaint with the health and social care ombudsman.

Are urgent and emergency services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **Requires improvement.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood priorities and issues the service faced. Leaders did not always take action to resolve the issues faced by the service. They were visible and approachable in the service for patients and staff.

The emergency department was led by the clinical director, supported by clinical leads, head of nursing and operations director. The paediatric emergency department came under the same management team. The emergency department was part of the urgent and emergency care group. The clinical director reports to the medical director for the trust.

The department was led locally by a matron for the emergency department that had been appointed four months prior to our inspection. Staff told us their introduction was a big improvement and were very supportive. We saw them supporting staff and patients.

There had been recent changes in the leadership of the service. The clinical director had been in post for less

than a month but had been with the service as a consultant before being promoted. The head of nursing had been in post for six months and the operations director had been in post for 12 months.

Leaders had the skills, knowledge, experience and integrity required to carry out their roles. They understood the challenges to quality and sustainability within the department and had proactive, ongoing action plans in place to address these. Managers reported that they had not yet been able to persuade senior managers to agree to some changes they thought were needed.

There was a clear, strong, clinical leadership presence in the department, and it was easy for staff to access and locate the consultant in charge of the shift. Their visibility was maintained throughout the inspection. Staff told us they felt well supported, well led, and that all local leadership staff were approachable. Staff told us when action was not taken their local leaders had been pressured by senior leadership to not act.

Vision and strategy

The service had a vision to improve services and a strategy to turn it into action. Leaders understood and knew how to apply their strategy and monitor progress. The vision and strategy were not understood by staff and they did not feel involved in their development or implementation.

Leaders had a clear idea of their vision to improve patient care and the strategy to implement this. This vision was 'great healthcare from great people'. This involved improvements to the built environment within the department and to review staffing levels. Staff told us they knew about these plans but had not been involved in making them. The service had a transformation team and had recently appointed a band 7 nurse from a patient facing role to be seconded to this team to give staff some involvement in strategy development.

Staff were not aware of the service's vision. No staff we spoke with could tell us what the vision for the service was.

Culture

Generally, staff felt respected and valued. They were focused on the needs of patients receiving care. The service did not always have an open culture where patients, their families and staff could raise concerns.

Staff we spoke with felt respected, valued and supported and spoke highly of their job despite the pressures and there was good team work and peer support. Staff were committed to delivering a best service possible given the resources they had. We saw when the department became busy, leaders would come and help.

All staff felt included and part of the team. We saw junior medical staff had no hesitation in asking about patients care or for support and advice. Allied health care professionals told us they felt part of the team even though they may be physically based away from the department. All staff we spoke with told us they felt they could raise concerns, and these would be listened to and their local managers would try to act on these concerns. However, staff told us they felt that action was not always taken as their managers came up against barrier with senior management. Some staff told us they felt senior managers were penalising them for raising concerns.

We saw there were suitable security arrangements to keep staff and others protected from violence. Staff told us they knew how to seek help. During the inspection, we saw a security presence in the department. Staff told us the security service were helpful and very quick to respond to any concerns.

Managers told us the culture in the department had changed over the past 12 months and had improved moral greatly over that period. Staff we spoke with also commented on the improvements over this period. One improvement made to identify the value placed on the hard work of the staff in this department was to implement a higher rate of pay for staff doing bank shifts in the department.

Governance

Leaders operated governance processes, throughout the service and with partner organisations but these were not always effective. Staff at junior levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss or learn from the performance of the service.

However, staff at senior levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The learning from senior staff was not shared with junior staff.

The service had governance processes throughout the service, however these had not delivered a safe service. Urgent and emergency care board meetings were held monthly. These meetings covered areas including; an emergency department update, finance, and human resources issues such as appraisal rates. Within the minutes from August 2019 we saw management at this meeting had identified issues relating to the confusion related to the escalation processes and identified some actions to improve this. When we visited the department in March 2020 the department was not clear on the process for escalation and did not result in the department getting the help needed.

Urgent and emergency care group leadership team meetings were meeting between the senior leadership team and the matrons in the care group. We looked at two sets of minutes from these meetings and saw these included standing agenda items included performance and finance. For example, highlighting an increase in corridor care in December and discussions about the cost improvement plan. However, we saw progression on improvements delayed by meetings being cancelled due to site pressures. These meeting were also used to share updates and care group news such as the concerns relating to maternity highlighted by a recent CQC inspection. When necessary, concerns discussed in this meeting were escalated to the urgent and emergency care board meetings. Updates and decisions made at the care group leadership team meeting were shared at the band 7 meetings.

Band 7 meetings were held alternate months with a band 6 and band 7 joint meeting held on the months between. These meetings were used to discuss serious incidents, topics the team wanted to discuss each month and updates from senior management meetings. This included discussion around training for fit testing related to the recent pandemic. However, sharing information down from this meeting to the other staff in the emergency department did not seem to work effectively. Staff below band 6 we spoke with told us they did not get updates about changes to policy or practice.

The service held meetings to review incidents, serious incidents, update policy, complaints, audits and pharmacy issues. Urgent and emergency care governance and patient safety meetings were held monthly. We looked at two set of minutes for this meeting and saw they identified gaps in standard operating procedures and how they were going to address these. We saw they identified the importance of sharing learning from incidents and complaints. However, staff we spoke with were not aware of any learning that had been shared with them.

The departments management held meetings with the subcontractor that supplied them with cleaning staff and porters. These meeting were a two-way communication about performance and improvement plans.

The department lacked consistent oversight and clear pathways to share information with patient facing staff. Junior staff told us they were unclear who would tell them about updates and that this did not happen routinely. Managers told us meetings were being cancelled due to high patient demand and staff vacancies.

The department had improved their governance team. They had recently recruited a dedicated governance team.

Managing risks, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact however, these were not always effective. They had plans to cope with unexpected events. Staff were not always included in decision-making to avoid financial pressures compromising the quality of care.

Managers knew about and reviewed the emergency department's (ED) risks. We looked at their risk register and found that they had identified risks, and all these had been reviewed in the previous month. Each risk was assessed for the impact and likelihood which were used to create a risk score and colour coded on their register to make clear which issues posed the greater risk. Three of the departments highest rated risks were; failure to follow the corridor standard operating policy and procedures, the risk to patient safety due to inability to meet demand

in the ED, and risk of failure to meet financial balance. For each of these the managers had identified the causes and the effects. They had a record of risk controls in place and a list of actions to be taken. However, the risk register showed for some risk's actions had not yet reduced the risk level.

The department was clear on who was responsible for each risk. The risk register showed the risk owner and if this had been delegated to another member of the team then their name was also recorded. Each action and control measure were assigned to an individual to be responsible for following up on. Managers we spoke with knew about these risks. Some staff we spoke with knew about the department's risks.

The department had a major incident plan. We looked at this plan which was up to date and had a review date planned. When we inspected the department, the department was responding to the initial patients related to the global pandemic. Staff knew how to respond to these patients and had been trained to wear personal protective equipment.

The department had an escalation plan however staff did not always follow this. When we inspected the department, staff were unclear on the level they were currently at in the escalation plan. We spoke with the operations director at the start of the second day to clarify what level they were currently on. They were unclear as to if the department was working at opal level three or opal level four. There was not a clear decision maker for deciding the opal level and sharing this with all staff. Patient facing staff we spoke with were unclear on the effect that a change in opal level had on their roles.

The service did not respond effectively to peeks in demand. The department was overcapacity on both days we visited. When the department appeared overcrowded, we asked to look at the departments full capacity and escalation policy this took management over 15 minutes to find. On reviewing these policies, we found that staff were not following these. Staff we spoke with felt helpless as they had reported their concerns through the routes, they understood to be correct and were told the hospital was working at opal level three meaning that they were still not escalating to the highest level (opal level four). We raised this to the attention of the management they informed us and then staff that the hospital was working at opal level four. This showed us the services escalation policies were not being effective as staff and management up and down were not using effective communication. The result was patients having to wait longer in the department to see clinical staff and increasing the number of patients for each nurse.

Staff were not always included in decision making to avoid financial pressures. Staff told us they had not been asked about cost improvement plans. However, other staff told us they had asked for additional pay for bank shifts and a retention premium to help reduce the agency staffing cost. Managers had implemented this improvement recently so far not seen its effect on agency staff costs but were monitoring this.

The department was aware that their risk and performance monitoring did not always achieve the desired result. They had a patient safety advisor team looking at their systems of managing risks and monitoring performance. This included looking at the feedback methods for the patient safety thermometer to ensure the ED can use this to improve. However, performance monitoring was not always used. There were audits to monitor the sepsis management performance however, not all staff were aware of these.

The department carried out local audits to monitor quality and patient safety. Audits included patient records, environmental cleanliness, hand hygiene and the safety checklists. However, not all audits were not structured in a way to clearly demonstrate the effect of improvement work.

Managers had used information to improve their performance since the last time we inspected. However, they had not managed to improve to the point that they met all the national targets.

Managing information

The service collected data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. However, were not all integrated together. Data or notifications were submitted to external organisations as required.

The service collected data and analysed it. We saw in the minutes from the care group board meeting discussion around the department's performance data. They had

identified the rate of patients leaving the department without being seen had increased and the rate unplanned reattenders was higher than the national average. The department had a manager assigned to investigate how they to reduce the number of patients needing to make unplanned reattendances to the ED.

Information systems were secure but did not always sync with each other. All computer systems were accessed with secure login via a keycode and smart card for each individual member of staff. The department had several systems for monitoring patient information and department performance. Staff showed us some of these systems communicated with each other however, there were also systems information had to be manual copied to as they did not communicate. Managers told us there was a new system due to be introduced soon that will improve this.

Not all data was easily accessible and used to make decisions. Managers showed us with easy how to find out how long patients had been waiting in the observation bay. We saw in meeting minutes a discussion about how to improve the length of time patients stayed in the observation bay. The observation bay was designed for patients to spend 24 hours in so patients that needed to stay longer than this should be admitted to a different ward. However, we also saw when we asked managers about simple information, they struggled to access this information such as how many patients are in the department. We saw in the observation ward there was a whiteboard where patients were being recorded and not recorded on the computer system meaning the information available to managers was not always reliable.

Staff were kept up to date with information sent out by managers. Managers sent messages to staff using a work social media group to highlight when there were new urgent emails staff needed to read. Confidential information was only sent through the NHS secure webmail service, so staff still needed to login to their email accounts to read message details.

Managers submitted information to external bodies as required. This included the department taking part in the Royal College of Emergency Medicine national audits.

Engagement

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

The emergency department gathered people's views and experiences and acted on them to shape and improve the service and culture. Patients took part in the friends and family test to provide feedback on their experience while in the department. Patients had the opportunity to provide feedback on their experience by test message after their discharge from the department.

The service built positive and collaborative working relationships with external partners, for example with other acute trust's, community health providers, mental health providers, and local charities. This included working with another acute trust on the introduction of their new care group model. Therapy team staff reported the departments relationship with the community providers had improved leading to less repeated assessment for patients.

The department had started team days that brought together staff on non-clinical days. These days focused on training and appraisals. Staff told us they enjoyed these and found it helpful to talk about concerns and about things that had gone well away from the busy environment of the department.

Leaders told us about a project to setup a social media group for staff to discuss none work topics. The aim was to promote a family atmosphere to the team. Staff reported working in the department felt like being part of a family.

Learning, continuous improvement and innovation

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

The department had plans to improve the layout and increase patient care areas. This included increasing the size of the main waiting area, adding an extra six trolley bay to the rapid assessment and treatment area, and creating a new acute patients' area for 11 patients on trolleys. Managers told us this work had been approved and was due to start next month. Managers also told us

they had submitted a business case for the additional staff needed for these extra patients however they also said there had been resistance to increasing the ED workforce as they had vacancies they were struggling to fill already. Some staff had been involved in planning these improvements, but we heard from other staff they had not been given any opportunity to add their experience to the improvement work. Staff told us on previous project they had not been consulted and the improvement had been helpful but would have been better with experience of the staff that work in the department every day.

The serviced had developed staff recruitment and retention initiatives since our last inspection, one was the development and education of staff. This had been applied to the middle grade medical staff with a successful outcome recruiting a large number leaving the service with only one vacancy left to fill. Mangers had plans to use this recruitment initiative for consultants and consultants offering post with 50% research time.

Staff in the rapid discharge team told us about improvement ideas they had. One of these was to increase the size of the team to allow them to perform home visits as some patients were discharge home without this and resulted in the patients being brought back to the department as the home was not as expected or described to the therapists. Staff told us they had suggested this but had not been supported by managers yet.

Some staff told us they had been involved and supported by managers in improvements. Staff told us about manual handling improvements which was initiated by a band five nurse. This included having a stock of slide sheets which before this were sourced from ward stocks on an individual basis.

The department had been involved in research projects to improve patient care into the future. We saw that staff had completed a research project around the way test result are reported which had won the Royal College of Emergency Medicine's 'Emergency Department Patient Safety Project of the Year Award 2019'.

Outstanding practice and areas for improvement

Outstanding practice

- The service had mental health support workers on every shift. This meant patients with mental health conditions were support by an experience support worker at all times in the department.
- The service had arranged with the local authority to fund five care packages a day to facilitate rapid discharge from the emergency department. This meant patients needing a care package did not need to be in hospital were able to return home without being admitted to wait for a care package.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure staff complete their mandatory training and each module meets their compliance targets, including; Mental Capacity Act training, life support training, and dementia training. Regulation 12 (2)(c)
- The trust must ensure all staff follow the trust's infection control policy. Regulation 17 (2)(b)
- The trust must ensure all equipment is kept visibly clean. Regulation 12 (2)(f)
- The trust must ensure all patients in corridors have a call bell. Regulation 17 (2)(b)
- The trust must ensure the department follows fire safety standards. Regulation 17 (2)(b)
- The trust must ensure all patients are monitored for deterioration including those waiting for triage. Regulation 17 (2)(b)
- The trust must ensure all hazardous substances are stored securely. Regulation 17 (2)(b)
- The trust must ensure all staff understand how the triage tool to be used and that staff use the information from this tool to inform the prioritization of patient care. Regulation 17 (2)(b)
- The trust must ensure all septic patients are screened and treatment is given in a timely way. Regulation 12 (2)(b)
- The trust must ensure the department has enough nursing staff at all times given the number of patients in the department and the acuity of these patients. Regulation 17 (2)(a)
- The trust must ensure they retain enough nursing staff to reduce their agency staff usage. Regulation 17 (2)(b)
- The trust must ensure medicines are stored securely, and staff complete records for controlled stationary. Regulation 12 (2)(g)
- The trust must ensure critical fluids and medicines are administered and recorded in a timely manner. Regulation 12 (2)(g)
- The trust must ensure managers do not prevent staff reporting incidents. Regulation 17
- The trust must ensure learning from incidents is shared with all staff. Regulation 17
- The trust must ensure they improve their unplanned reattendance rate to be in line with the national target. Regulation 12 (2)(b)
- The trust must ensure they improve their monitoring of the improvement actions on patient outcomes. Regulation 17
- The trust must ensure the layout of the department protects patient's privacy and dignity. Regulation 17 (2)(a)
- The trust must ensure the department had suitable facilities to care for patients with mental ill health. Regulation 12 (2)(b)

Outstanding practice and areas for improvement

- The trust must ensure all staff understand and follow the trust's escalation policy. Regulation 17 (2)(b)
- The trust must ensure all patients receive a safe discharge. Regulation 12 (2)(b)
- The trust must improve their approach to meeting the Department of Health's standard for 95% of patients to be admitted, transferred or discharged within four hours. Regulation 17
- The trust must ensure senior management do not create barriers to improvement. Regulation 17
- The trust must ensure their governance processes link with all staff to provide a safe service. Regulation 17

Action the provider SHOULD take to improve

- The trust should ensure all staff have access to the training needed for their role including advanced life support.
- The trust should ensure items awaiting cleaning are stored secure areas.
- The trust should ensure the department is kept secure.
- The trust should ensure equipment is maintained to prevent unnecessary risks.
- The trust should ensure the environment is designed in a way to promote safety of patients and prevent routine overcrowding in the department.
- The trust should ensure all patients have risks assessed and intervention put in to reduce these risks.
- The trust should ensure staff can access patient's records quickly and easily without the need to duplicate information.
- The trust should ensure staff have a system that allows them to record all observations without delay.
- The trust should ensure specialist advise is sought and implemented to ensure medical gas cylinders are stored appropriately.
- The trust should ensure medicines reconciliation is undertaken in a timely manner.
- The trust should ensure all patients have pain assessed, recorded, and analgesia given when needed.
- The trust should ensure all staff have an appraisal.
- The trust should ensure all patients know how to make a complaint about their care including how to find the trust's patient's complaints team.
- The trust should ensure all staff have the information needed to understand performance, make decisions and make improvements.
- The trust should consider their approach to the organisation of equipment on resuscitation trollies.
- The trust should consider their approach meeting the needs of relatives and friends in the department.
- The trust should consider their approach to meeting the staffing guidance from the Royal College of Emergency Medicine.
- The trust should consider how to recruit a full establishment of emergency department consultants.
- The trust should consider their approach to staff uniforms for those caring for patients with mental ill health.
- The trust should consider their approach to meeting the needs of patients living with dementia.
- The trust should consider their approach to meeting the 15-minute triage target consistently throughout the day and night.
- The trust should consider their approach to involving all staff in the creation of a joint vision for the service.
- The trust should consider their approach to involving all staff in the decision making to avoid financial pressures compromising the quality of patient care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance