Queen Elizabeth The Queen Mother 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

Overall rating for this location	**Requires improvement**
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.

Summary of findings

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

Overall summary

Queen Elizabeth The Queen Mother Hospital is operated by East Kent Hospitals University NHS Foundation Trust. It provides surgery, medical care, services for children and young people and outpatients and diagnostic imaging, surgery, maternity and a minor injuries unit with an emergency care centre. We inspected the urgent and emergency care service.

The trust became an NHS foundation trust in 2009. It has five hospitals serving the local population of around 695,000 people throughout 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. The trust receives over 200,000 emergency attendances, 158,000 inpatient spells and one million outpatient attendances between December 2018 and December 2019.

NHS Improvement 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 trusts year-end target against its budget). The trust was still in financial special measures at the time of the inspection.

We inspected this service 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:

- Not all staff had completed mandatory training.
- The service generally used systems and processes to safely prescribe, administer, record and store medicines. However, not all medications had been given as prescribed.
- Staff could not be assured that processes ensured patients received the correct medicines in a timely manner, as pharmacy staff could not always review all patients' medicines.
- Staff did not always use monitoring information to assess and improve effectiveness of care and treatment.
- Not all people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards but had improved since our last inspection.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead

Summary of findings

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.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. Most people could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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: accident and emergency department that provided a 24-hour, seven day a week service. The emergency department consisted of a major treatment area with four cubicles and four chair areas, a minor treatment area with eight cubicles, a resuscitation room with four trolley bays (including one for children) and a new rapid assessment and treatment area. Children and young people had a separate waiting and treatment area. There were separate rooms for mental health assessment, eye examinations and the application of plaster casts. Adjacent to the emergency department was a newly formed urgent care centre for the treatment of patients with minor illnesses and injuries.

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Background to Queen Elizabeth The Queen Mother Hospital

East Kent Hospitals University NHS Foundation Trust delivers a range of urgent and emergency services from four hospitals in the region. The urgent and emergency care department at Queen Elizabeth The Queen Mother Hospital provides emergency care to people living in Margate and Thanet in Kent and serves a mixed population.

The emergency department had a four-bed resuscitation bay, 10 major cubicles, a mental health assessment room, seven minor injury assessment bays, a plaster room and a clinical procedure room. There was an observation area, which had four bays. There was a separate area for children, which had a waiting area, and three designated child treatment cubicles. There was also a designated child resuscitation bay in the resuscitation area. There was an x-ray facility in the emergency department.

Queen Elizabeth The Queen Mother Hospital was 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, an inspection manager, a pharmacy inspector and two specialist advisors with expertise in urgent and emergency care. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Queen Elizabeth The Queen Mother Hospital

Queen Elizabeth the Queen Mother Hospital was originally built in the 1930s although most services have been relocated to the newer main hospital building. It is an acute hospital located in Margate, Kent. It serves the community of East Kent providing an extensive range of inpatient, outpatient and elective and emergency services. It has a postgraduate teaching centre that works in coordination with the local university.

Our inspection was announced, meaning that staff knew we were coming. We inspected all five key questions. We spoke with 11 patients and carers and over 30 staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 30 sets of records. Before and after our inspection, we reviewed performance information about the trust and information provided to us by the trust.

The hospital has been inspected three times. The most recent inspection was in May 2018. At the last inspection in 2018 we rated safe and caring as good and responsive, effective and well-led 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 emergency and urgent care services.

Summary of this inspection

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

Track record on safety (January 2019 to December 2019)

- Zero Never events for this service.
- 34 serious incidents.
- 115 complaints

Services provided at the hospital under service level agreement:

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

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	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Urgent and emergency services

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

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 received and kept up-to-date with most of their mandatory training. The trust advised that training compliance was reported on a month by month rolling basis. Nursing staff had eight mandatory modules. The compliance with these modules was; 94% for moving and handling, 93% for fire safety, 97% for health and safety, 94% for information governance, 100% for infection prevention and control, 97% for equality and diversity, 70% for dementia awareness, 80% for prevent radicalisation, 63% for hospital life support (intermediate life support), and 57% for paediatric life support. The service met their target of 85% for six modules out of these ten modules.

Nursing staff attended training in areas that included dementia awareness, mental capacity, infection control, manual handling, resuscitation and life support. Staff also attended training that related to their specific role including safeguarding children and paediatric life support. Senior staff told us that level three safeguarding training had been provided for all staff.

The mandatory training was comprehensive and met the needs of patients and staff. Staff could access training online and face to face. One nurse told us that if they needed to complete training, they were able to do so at work and the time was protected so it could be done without being interrupted.

Medical staff received mandatory training however, not all medical staff keep up-to-date with this. Medical staff had ten mandatory modules. The compliance with these modules was; 88% for moving and handling, 82% for fire safety, 85% for health and safety, 79% for information governance, 85% for infection prevention and control, 88% for equality and diversity, 50% for dementia awareness, 75% for prevent radicalisation, 76% for hospital life support, and 82% for paediatric life support. The service met their target of 85% for four modules out of these ten modules. 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. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and had systems to alert staff when they needed to update their training. At the last comprehensive inspection training targets were not met for all clinical staff and compliance had improved. Staff could access an online system where their individual training was recorded. This showed them their level of compliance with mandatory training and told them when they were due to update topics. This was

workplace specific so allowed them to make this a personal and department focused record. Staff were told if their training was due and managers kept electronic records to monitor this.

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.

Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff told us they were supported by the safeguarding team and able to discuss safeguarding and any concerns they had in how to recognise and report them.

A breakdown of compliance for safeguarding training courses as at 31 December 2019 for qualified nursing staff in urgent and emergency care showed 100% of staff had completed safeguarding children level 1. Nursing staff received safeguarding children level 3 training with a compliance rate of 94% which met the trusts target. Nursing staff received safeguarding vulnerable adults' level 2 training with a compliance of 88% which met 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 79% which was below the trusts target of 85%. Medical staff received safeguarding vulnerable adults' level 2 training with a compliance rate of 100%, which was better than the trust's target of 85%.

A breakdown of compliance for safeguarding training courses as at 31 December 2019 for medical staff in urgent and emergency care was met for one of the four safeguarding training modules for which medical staff were eligible.

Staff had a good understanding of the national "Think Child" campaign and could provide examples of when a child may be vulnerable. Further, staff could describe examples of what may constitute a vulnerable person including those at risk of neglect, financial abuse, child sexual exploitation, female genital mutilation, domestic violence and abuse.

An up to date safeguarding policy covered all aspects of safeguarding including female genital mutilation and child sexual exploitation. Staff showed us the process for accessing policies on the trust intranet. Guidelines and information were available to support staff to recognise and manage cases of suspected domestic violence or sexual assaults. Patient information was available across the department including information relating to domestic violence being placed in the public toilets.

There was a hospital safeguarding team for children with staff responsible for children who were being looked after by foster parents and carers. Staff with roles that had responsibility for children were expected to have level three training. Training records confirmed staff had completed the training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to make a safeguarding referral for both adults and children. Staff used an email address to refer adults. For children they completed a yellow form for the notes and an interagency form online. Staff used a checklist in the paediatric referral form. One nurse told us they had received a very quick response to a referral. Out of hours staff would complete the forms, raise it with the nurse in charge and doctor looking after the patient or contact the paediatrician on call. Staff making a referral for a child told us that they would receive feedback following the referral with learning points. They told us that this was very helpful.

We reviewed eight sets of notes specifically relating to the care of children. In each case, staff considered the history provided by parents to consider whether the presenting injury was appropriately explained. Care records included "Red flag" concerns which were completed in each case. Red flag concerns prompted staff to consider subtle safeguarding concerns and to explore any specific areas of concern including domestic violence, multiple hospital or health-professional contacts as well as those at risk of neglect.

The department had paediatric trained staff on each shift and staff could attend paediatric study days to maintain skills. Staff followed safe procedures for children visiting the emergency department. Staff working in the paediatric unit told us they had training in child safeguarding and were able to talk to the child safeguarding lead if they needed advice.

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

Cleanliness, infection control and hygiene

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

There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. Staff followed infection control principles including the use of personal protective equipment. Staff adhered to the infection control policy. All staff we saw were bare below the elbows and we saw them use personal protective equipment, when needed, in line with best practice.

All areas were clean and had suitable furnishings which were clean and well-maintained. Seats were all made from a wipeable material which helped prevent the spread of infection. We saw that the waiting area in both the emergency department and paediatric unit were clean and tidy. There were seven chairs for ambulatory care, all looked clean. The clean utility room was locked.

Consumables were stored in an orderly fashion and all those checked were in date. The cleaning cupboards were identifiable with hazard signs on the outside. The dirty utility room and cleaning cupboards were locked, visibly clean and stock was tidy. The service was audited each month by the infection control team. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Hand sanitisers were available throughout the department and we saw staff using them. Every sink area had signage advising staff on how to ensure hand hygiene. We saw staff use the sinks frequently and following the guidance, including washing up to and above elbows. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

We looked at three hand hygiene audits completed between January 2020 and February 2020 these showed that compliance from 75% to 91% with trust policy. The also showed compliance with the trust policy on "bare below the elbow", compliance varied from 91% to 100%. These audits also included immediate action taken to remind staff of best practice.

There were toilet facilities available for patients. In the observation ward there were two bays one male and one female, with four beds in each. There was a dedicated toilet for each bay. Disposable curtains had been changed within the previous six months, in line with guidance. Since the last inspection in 2018, staff working in the triage area had direct access to handwashing facilities.

At the last inspection there was no assurance of the cleaning of children's toys. At this inspection we saw the cleaning log of the toys and play equipment in the children's department, which showed that the toys were cleaned every day. We also saw staff cleaning the equipment as well as the toys during the morning and afternoon shifts.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The emergency department was designed to allow staff to see most patients. Staff were allocated to work in specific areas within the department. These were majors assessment, majors treatment, a minor treatment area, a resuscitation room with four trolley bays (including one for children), an observation ward and a rapid assessment and treatment area for the assessment of patients brought to the department by ambulance. The introduction of the rapid assessment and treatment bays had improved the time patients waited for assessments and provided improved privacy for patients at handovers and consultation. Children and young people had a separate waiting room and treatment area.

There was a designated room for seeing patients who required a mental health assessment and it met the Psychiatric Liaison Accreditation Network quality standard requirements. It had a panic strip along the wall which staff could use to summon assistance or help, and

heavy furniture that could not be thrown easily. However, outside there was a hoist with various slings which posed a ligature risk and the observation cameras did not cover that area.

The department had a dedicated ambulance entrance, which was located near to the majors treatment and resuscitation areas. A helicopter landing pad was situated close to the department to enable air ambulances to land.

An adjacent imaging department provided X-rays and scans for walking patients and those on trolleys or beds.

The toilets in the paediatric unit were suitable for the disabled and to use as baby changing facilities. The room had no ligature points which reduced the risk of patients self-harming. At the last inspection there was concern regarding the toilets having pull cords which posed a ligature risk. We saw these had been replaced.

Staff carried out daily safety checks of specialist equipment. We saw that resuscitation trolleys were tamper evident and locked with secure tabs. This meant that it was easy to see if the trolley had been opened. Staff completed daily checks of the trolleys to make sure that all the contents were present and in date. We checked a range of specialist equipment, including adult and children's resuscitation equipment. There were checklists for the trolley contents, these checks were completed regularly. There were daily checklists for the top of the trolley items and these checklists were not complete for 20 October 2019, 5 December 2020 and from the 26 to 28 February 2020 inclusive. Several staff told us they felt sure the checks had been completed but they had not been recorded.

In the resuscitation department we reviewed the paediatric bay. We noted that all the disposable equipment was labelled and in date. There were guidelines on paediatric care on the walls that were in date. Staff told us there was a distraction box available for very young patients. The area was clean and tidy with some child friendly décor.

Patients could reach call bells and staff responded quickly when called. However, we noted there were no call bells in the paediatric unit. Staff told us that patients were not left alone in these areas as they were either with relatives or with staff.

The service had suitable facilities to meet the needs of patient's families. There were 36 seats in the main waiting area. However, all seats were the same specification which meant there may not be suitable seating available for those who required a higher seat or for bariatric patients. The paediatric area had their own waiting area with same size seating. We observed family members sat with patients in the cubicles in both majors and the corridor.

The service had enough suitable equipment to help them to safely care for patients. Equipment was checked and tested and within its review date. We checked 16 pieces of equipment for portable appliance testing. Portable appliance testing is the testing of electronic equipment to ensure safe to use. We checked portable monitors, hoists and ultrasound scanners. All pieces of equipment had a sticker to indicate the date the piece of equipment was tested and its next test date. The next test date was 12 months from the date the equipment was last tested. Staff had a record of all the equipment in the department. They were able to arrange for equipment to be repaired and were also contacted by the servicing team a week before the expiry date to send equipment for routine testing.

We asked staff how they would identify how a piece of equipment was safe to use. Staff were able to identify the portable appliance testing stickers and indicated that they would only use the equipment if the next test date had not passed. Any member of staff was able to request a repair and would complete a form for the housekeeping team to forward with the equipment. Staff told us they would tell the nurse in charge and label the equipment as broken.

We asked staff how they were assured they could use the equipment safely and they told us they undertook competency training on certain pieces of equipment. We were able to see the competencies for the staff to evidence this.

Staff disposed of clinical waste safely. The dirty utility room in the main department was tidy and accessible through two doors. We saw three commodes that were visibly clean and labelled for use. There was a cupboard for the storage of cleaning solutions that was locked.

There were no cleaning solutions left on show. Clinical waste bags in the room were separated and stored safely. There was a smaller utility room in majors two that was also clean and tidy.

We checked seven yellow bins used for the disposal of sharps. Sharp bins should be signed and dated on the day the bin was opened, with location and area information also recorded on the bin. All the sharps bins were labelled correctly.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission and arrival, using a recognised tool and reviewed this regularly, including after any incident. There were two routes for admission into the department for patients, walk-in and via ambulance.

Patients who were able to walk in to the department were first seen in the streaming area. Here we observed a nurse taking initial information and completing an assessment. This included asking about pain and pain relief was offered to patients where needed. Staff could take the patient into a separate room if the assessment required a more thorough discussion. Staff would then direct the patient to reception to sign-in while waiting to see a nurse practitioner or GP. If the patient was assessed as needing to be seen in the main department they were then taken to the rapid assessment and treatment area, directed to the main department, paediatric unit or resuscitation area.

Initial assessment (triage) of ambulance patients was in line with guidance produced by the Royal College of Emergency Medicine and the Royal College of Nursing. The guidance states that "triage is a face-to-face contact with the patient" and that it should be carried out by a qualified healthcare professional who has had specific training. This assessment was required to determine the seriousness of the patient's condition and to make immediate plans for their on-going care.

Staff kept people safe by using a standard procedure for initial assessment of patients including those that do not arrive by ambulance. Triage was carried out within 15 minutes by emergency service nurses who had been trained, with face-to-face contact with patients. The triage nurse spoke with the ambulance crew, patient and any accompanying friends or relatives. They completed an initial paper-based assessment, which was later transferred onto the electronic system. Ambulance staff told us, that in their experience, the department was one of the better emergency departments at this initial triage process.

Patients that did not arrive by ambulance were greeted by a nurse on walking into the department that would stream patients. This streaming allowed patients that were attending for minor injuries or minor illness to be immediately diverted to the urgent care centre. This nurse also used a colour coded system to identify those patients needing the most urgent triage. Then patients went to be booked in by a receptionist. Patients would then be seen by the triage nurse. Triage nurses did observations and gave patient pain relief when needed. These triage nurses could observe the wait area to identify any patients that became worse while waiting for triage. We looked at five records that all showed that triage had been completed within 15 minutes which is in line with national guidance.

During this inspection the department was busy, however we did not observe ambulances waiting outside the department. The national standard is for patients to be handed over to staff and for assessment to begin within 15 minutes. Staff told us that if the area was busy a senior member of staff would assist in assessing patients. They would try to complete assessments such as electrocardiograms (heart monitoring), if possible, before transferring the patient to a ward. Nurses told us they followed set pathways to assist in directing patients to the correct service. These included early pregnancy and breathlessness referral pathways.

The 'live patient tracking list' made it possible to see how long patients had been in the department, what investigations had been done and when results were available. Two-hourly rounds took place where medical, nursing staff and others, such as physiotherapists, saw patients in the department. Senior staff monitored the electronic records system to ensure observations took place at the recommended time and reminded staff if needed.

Requires improvement

Urgent and emergency services

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. The national early warning score (NEWS2) was used for adults and the paediatric early warning score was used for children and young people. 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. We looked at the records of 15 adult patients in the majors treatment area and eight records for children and young people. All had had an early warning score calculated when they arrived and at regular intervals during their stay in the department. Records showed that patient's conditions were escalated when their national early warning score or paediatric early warning score required it.

The department carried out audits of compliance with NEWS2 completion. We looked at the results from January 2020 which showed 100% 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.

Staff knew about and dealt with any specific risk issues. During the inspection the department had been informed that an ambulance was bringing in a patient who had been assessed for potential flu like symptoms possibly related to Covid-19. On arrival they were taken to a side room which had been put aside for such an event. Outside the room temporary barriers were placed to prevent people walking past. There was infection control equipment available outside the room. The department managed the situation well, and once the patient had been made comfortable, they were moved with their family through the department to another area for specialised care. The room was then allocated for a deep clean in preparation for any future needs.

A range of clinical pathways existed which ensured patients presenting with specific conditions could expect to receive standardised care and treatment aligned to best practice recommendations. Junior medical and nursing staff could describe the process for the management of sepsis, including the use of a 'Sepsis 6' assessment tool. A review of clinical notes confirmed staff routinely used the sepsis 6 care bundle. Clinical guidelines supported staff in managing sepsis; the trust antibiotic guideline, accessible from the trust intranet, included guidance for the management of sepsis of an unknown origin for example.

Suspected or confirmed cases of sepsis (a life-threatening infection of the blood) were managed effectively using the Sepsis 6 care bundle. Audit findings showed improvement in relation to the screening and management of patients with sepsis. In the paediatric unit there were clear escalation guidelines on the wall to the nurse in charge.

We observed rapid attendance of clinical specialities to the emergency department when pre-alert calls were received from the ambulance service. Members of the stroke team responded to all stroke calls, even if medical history suggested the patient was outside the optimal window for thrombolysis. Members of the trauma team arrived at the resuscitation area with minimal delay. Health professionals were well prepared and were aware of their roles and responsibilities for managing specific conditions.

Staff told us that they would call an emergency number if they required assistance or the emergency buzzer for a medical emergency. They told us that doctors would make a call to specialist teams for further assistance if necessary.

The department had introduced a GP service. The GP told us they worked with GP 's in the community and with the hospital staff. In one case we saw the GP referred a patient back to the emergency department after their assessment found the patient needed admitting to the hospital.

Senior staff aimed to only place patients in the corridor who were mobile, due to be transferred to a ward or another area of the department. Senior staff told us that staff were allocated to look after patients in the corridor. We heard staff offering patients food and drink. We saw that patients were cared for in the corridor for the least amount of time possible.

We spoke with clinical and administration staff who told us they had training in conflict management. Staff would try to de-escalate aggression with verbal and body language. We were told that they felt very well supported by senior members of the team when such incidents

occurred. In the main department there were three rooms staff could use to give the patient or relatives time to calm down. During the inspection we saw these rooms being used by the police as a place of safety for patients.

Staff told us they were not trained to use restraint but had to become involved in restraining patients who were violent and aggressive when administering tranquilising medicines. Tranquilisation medicines are medicines used to sedate patients who pose a risk to others and or themselves. Security staff had licences from the Security Industry Authority with training in safe restraint and conflict resolution. These skills enabled them to take the lead in the process with nurses and doctors present. If a patient had to be sedated by doctors, the security team told us that they would not restrain the patient unless the doctor documented the need. We saw that security staff were available through the day in the emergency department. The trust employed mental health support workers who were trained in safe restraint as part of their role. All mental health support workers were up-to-date with this training. The trust told us 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 trusts mandatory training for all emergency department staff.

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a patient's mental health). Senior staff could book a registered mental health nurse and they had support workers who had undertaken extra training in mental health.

The psychiatric liaison team told us that they found the mental health assessment room appropriate and generally available for use. The room had no ligature points, a strip alarm for staff and patients to call for help and furniture that could be removed if required.

Staff shared key information to keep patients safe when handing over their care to others. Nurses told us they were able to request help from doctors in managing patients and that the doctors respected their judgement. Doctors and nursing staff discussed each patient, allocated jobs to each staff member and talked through pressures and risks in the department and service. The meeting was held in the department. At the morning meeting the night nurse co-ordinator gave a report of activity overnight, the number of beds in the department and patients being cared for in the corridor. Staff were allocated areas of the department to work in and a senior member of staff for that team attended the patient safety meetings that took place every two hours.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staff told us that staffing was managed well.

The staffing ratio on the rota was 14 nurses and seven support workers and technicians. The matron for the service had recently agreed for an additional nurse to work in the department. The rotas showed that this had been implemented. There was an escalation process, whereby the site team were contacted if extra staff were required. The matron told us they never had difficulty getting extra staff if they were needed.

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.

On the morning of 4 March 2020, the majors area had ten patients and three nurses. This equates to one nurse for every 3.3 patients which met the Royal College of Emergency Medicine guidance. On the evening of 4 March 2020, this area had nine patients and four nurses. This equates to one nurse for every 2.25 patients which met the Royal College of Emergency Medicine guidance.

However, on the morning of 3 March 2020 there were 14 patients and three nurses in the majors area. This equates to one nurse for every 4.6 patients which did not meet the Royal College of Emergency Medicine guidance.

The department manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. The nurse-in-charge reviewed nurse staffing regularly throughout the day. For example, two nurses and two support staff were allocated to the observation ward and were moved around the department depending on patient movement. This was in line with the nurse allocation chart senior leaders showed us.

Senior staff told us staffing for the paediatric emergency department was on the paediatric risk register. It was staffed safely with two children's nurses and a health care support worker, throughout the day. One nurse was always a member of trust staff and they used regular agency nurses to fill the other role. A doctor was allocated from the main emergency department team and there was also medical support from the wards.

There was a daily call for paediatric wards and the emergency departments at Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital to discuss staffing concerns or gaps so they could support across all areas.

Medical staffing

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

The service had enough medical staff to keep patients safe. However, the senior management team acknowledged that there was a significant issue with recruiting senior grade doctors. They told us they were working towards ways of addressing this.

At the last inspection the department had not been able to meet workforce recommendations of consultant hours. Staff told us that although there were consultant vacancies, staffing was managed well. There were 12 medical staff per shift with a mixture of senior and junior staff. The consultant cover now met workforce recommendations with consultant cover 16-hours a day.

In the children's area there were paediatric trained doctors and further support was available from the paediatric ward. Handovers took place at the start of each shift and every two hours there was a patient check.

Records

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Staff showed us the electronic patient record system. Emergency department admission notes, for patients who had come in via ambulance, were completed on paper and were scanned onto the system by administrative staff.

Patient records were clear with evidence of ongoing care noted. We reviewed 18 sets of patient records, five in paediatrics, and 13 in the adult area. The notes were all dated and signed. Observations to monitor the patients were completed and recorded. We saw that all records had patient demographics recorded. If needed, therapy team assessments, care pathways and care bundles were fully completed and signed. Risk assessments were completed and signed, repositioning care records were completed where needed and there was a record of tests for infections if the decision was made to admit a patient.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic patient record was used to record information such as time they arrived in department and their location. The notes reported how the patient had arrived at the hospital. The department had an electronic system to monitor the patients treatment and time in the department. The patient name changed colour once they had been assessed by the clinician. Other symbols noted how long the patient had been in the department and when they had been seen by other professional such as physiotherapy.

Records were stored securely. Paper records were kept in the staff area or were kept in trolleys which were locked, and nurses and medical staff could access them.

Requires improvement

Urgent and emergency services

Medicines

The service used systems and processes which mostly safely prescribed, administered, recorded and stored medicines.

We reviewed ten medicine charts for patients in the emergency department. This included patients who had been in the department for over 12 hours. Where medicines had been prescribed staff had recorded when they had administered them, and the records were clear and easy to understand. This was not the case in all areas where patients had been transferred from the emergency department. We reviewed three medicines charts of patients recently transferred from the emergency department to the medical assessment unit. Two out of the three patients' medicines charts were incomplete for one dose of a regularly prescribed antibiotic to be administered by injection, that should have been administered in the emergency department. In one case the medical assessment unit staff had identified the incomplete record but were unable to resolve whether the dose had been administered. Two senior medical assessment unit staff told us that they occasionally received incomplete records where they had not been able to clarify, if medicines had been administered.

We reviewed the controlled drugs register in resuscitation and saw records were correctly completed apart from when a part dose was administered the remaining part not administered had not been recorded. Medicines requiring refrigeration were held centrally in a fridge in the resuscitation room, the temperature monitoring records indicated the fridge had been outside the recommended temperature range on two occasions in February 2020.

Within resuscitation, piped medical air was available within each bay. However, only three of the four outlets were capped, potentially allowing air to be administered when generally oxygen is prescribed. At the last inspection there had been an issue with the storage of full and used oxygen cylinders. This had been resolved and we saw that the storage of oxygen cylinders was safe.

Staff reviewed patient's medicines regularly and asked how they felt now that they were receiving them. The staff also provided specific advice to patients and carers about their medicines when being discharged.

Prescription pads were stored securely, and records were maintained that would identify gaps in the recording when they were used.

Triage nurses and other emergency department staff explained how they identified and clarified the medicines patients were taking prior to their attendance at the emergency department. Pharmacists based in the medical assessment unit visited the emergency department from Monday to Friday to provide pharmaceutical advice to the clinical and nursing staff.

Pharmacy staff we spoke with were concerned that they were not consistently 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. Pharmacy staff undertook a pilot project in December 2019. Over a period of four hours per day over four days, a pharmacist recorded reviewing 39 patients' medicines and they made at least 18 interventions to reduce the likelihood of adverse drug reactions.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised any concerns with the nurse in charge and complete an electronic reporting form. Staff were made aware of incidents via team meetings and handovers.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff used the datix online system to report incidents as required by the policy used in the trust.

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.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when, things went wrong. We spoke with five members of staff who were able to explain duty of candour. They told us that they understood the importance of being open and honest with patients and relatives.

Staff received feedback from investigation of incidents. Staff met in team meetings and were able to discuss the feedback and look at improvements to patient care.

Following the last inspection in 2018 there was evidence that changes had been made as a result of feedback. We saw a large poster of quality improvement projects displayed in the department, for example the walk in area and the expansion of the department. This invited staff and visitors to share feedback and ideas for improvements.

Managers debriefed and supported staff after any serious incident. Senior staff told us that there were regular meetings where staff were able to call in or attend in person to discuss serious incidents in the department. Staff could talk to senior staff immediately after an incident and staff were very supportive.

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

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.

Patient care and treatment was planned and delivered in line with up to date evidence-based guidance and standards set by organisations like the National Institute for Health and Care Excellence (NICE), Surviving Sepsis Campaign, the British Thoracic Society and the Royal College of Emergency Medicine. Guidance was regularly discussed at team meetings, and regular audits were completed and learning opportunities shared with staff.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Most of the policies we saw had been reviewed recently. Others had not been reviewed since 2018, however senior staff told us there was a plan to ensure all policies and guidance were up to date with a timescale for completion by end of 2020. The service reviewed compliance with the National Institute for Health and Care Excellence (NICE) guidance regularly. There was a clinical governance lead who was responsible for reporting on these to the trust board and ensured they were being followed.

Staff used local guidance alongside internationally developed tools to help screen and manage patients presenting with issues such as trauma or sepsis. They also monitored how well staff followed guidance when caring for patients and where appropriate, liaised closely with local commissioning groups, keeping them informed of progress in relation to care standards. For example, the department had worked to deliver a Commissioning for Quality and Innovation (CQUIN) project associated with safe sepsis management.

A range of clinical care pathways and proformas had been developed in accordance with national guidelines. These included treatment of stroke, sepsis, asthma, fractured neck of femur (broken hips), acute coronary syndrome and mental health problems. We found these were understood by staff and were being used effectively to manage patients' care. For example, psychological assessments were carried out following any episode of self-harm which was consistent with NICE guidance.

Staff demonstrated that clinical guidelines were easily accessible and were regularly updated. The department informed staff of updates to guidelines on notice boards, at board rounds and on display boards which were located across the department.

We saw examples of national guidelines (such as Surviving Sepsis Campaign: International Guidelines for

Management of Sepsis and Septic Shock 2016) being referred to in local policies and procedures. We observed one episode of care in which a patient's care was managed and treated in line with the sepsis policy. This included a timely initial assessment, administration of antibiotics within one hour, administration of oxygen and strict monitoring of the patient's fluid balance (the amount of fluid provided to the patient measured against the amount of urine the patient passed).

Paediatric staff were able to access up to date treatment guidelines on line. These included managing fevers, with and without a rash, abdominal pain, head injury, urinary infections, diarrhoea and vomiting. The psychiatric liaison team told us they would follow national guidance when prescribing and reviewing medication.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff referred patients where they suspected they were experiencing depression, for a mental health assessment. There were triaging forms for vulnerable adults to help staff screen patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Hydration and nutrition risks were routinely assessed for each patient on the short stay assessment unit. Staff used a range of nationally recognised tools including 'MUST' (malnutrition universal screening tool). Staff completed patient's fluid balance and nutrition charts where needed.

Water was available in all areas of the department and patients had drinks to hand. We observed a member of the housekeeping staff regularly offering hot or cold drinks, sandwiches and hot meals to patients.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The waiting area had vending machines for coffee, snacks, cold drinks, and a water dispenser.

We asked patients if they had been offered food and drink during their stay. All patients asked had been offered food and drink. A relative also commented that they had been offered food and drinks 'which was nice as they could be with their family member'. Patients in the paediatric unit also had drinks available.

Pain relief

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

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff asking patients to describe levels of pain they were in and being offered pain relief if they requested it.

Patients received pain relief soon after it was identified they needed it, or they requested it. Patients told us they were offered pain relieving medication on a regular basis. We reviewed 14 adult and paediatric records all of which recorded regular assessments of pain. Staff assessed pain using a recognised tool. A recognised tool was used for recording pain scores. Staff were able to direct us to age appropriate pain scoring systems which could be used for young children and those who could not verbally communicate.

Patient outcomes

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

Staff told us that senior staff members took the lead for a specific audit and actions plans were shared with staff.

Staff completed a hand hygiene and national early warning score audit every month. Staff told us there was no formal report of the outcomes, but that staff had feedback on an individual basis or during study days.

The service participated in relevant national clinical audits. The trust had a sepsis lead who attended network meetings. Other audits included antibiotic prescription audits and the trust had just participated in the new Royal College of Emergency Medicine audits which was waiting to be published.

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 improvements.

The service had undertaken an audit of chest X-ray reviews which had resulted in a change in the standard operating practice for chest X-ray reporting in the department. The resuscitation and airway management audit resulted in the introduction of an emergency intubation (where a tube is inserted into the airway to help a patient breathe) proforma and an airways standard operating procedure.

Learning outcomes from the renal colic audit, included a new flowchart, teaching sessions for junior doctors and the nursing team, a focus on raising the awareness of the recognition of renal colic and the administration of analgesia just after booking patients in.

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 that they believed the opportunities to have additional training had improved in the last year both in the main department and in the paediatric unit. This training included training in specialist nursing intervention for taking blood, being able to develop additional skills in paediatric care and learning skills that allowed them to work in other departments.

The matron told us learning and development was encouraged. All 'streaming' staff had undertaken competency training to ensure a safer service. There were staff development days which involved all staff and where possible included the domestic staff. We saw an example of topics on development days, the structure was teaching in the morning, with practical sessions in the afternoon. We saw a teaching session included training in diabetes following from a serious incident, to shared learning and staff updates.

Staff told us that they were well supported in their development and were able to access training from

within the trust and from specialist nurses in the emergency department, if the training was not available trust wide; for example, specialist skills such as cannulation.

Staff in the rapid assessment and treatment area told us they had additional training in identifying where to send patients after they had been assessed.

Managers gave all new staff a full induction tailored to their role before they started work.

New staff told us they had had a good induction and were currently supernumerary and had observed different areas of the department.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The 18 staff we spoke with told us they had had an appraisal. They said they were able to discuss training needs and found it easy to talk to their managers. The administration staff we spoke with told us they had received an appraisal within the last year.

Staff said they felt it was a useful process, they happened regularly and gave us examples of courses they had been on as a result of their personal development programmes.

The department met their target of 85% for compliance with yearly appraisals. Nursing staff appraisal compliance rate was 89%. Medical staff appraisal compliance was 100%.

Senior nurses told us they attended development days and had access to leadership courses. Nursing staff were able to identify additional training at any time during the year and did not have to wait until their appraisal.

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. We saw staff from different disciplines working together to assess patients. We spoke with occupational therapists who had received a verbal referral from a doctor to see a patient. They checked the time the patient had been in the department to see if they were about to breach the four hour target before seeing the patient. Staff worked closely with nurse specialist teams including community services. This meant that patients care was discussed with other health care professionals to plan care and treatment.

Staff referred patients for mental health assessments when they showed signs of mental ill health for example depression. Psychiatric liaison staff told us the emergency department staff were very good at alerting the team to appropriate patients. They told us staff treated patients with respect and the liaison team left care plans in patient records for ongoing care including advice on managing symptoms. Staff were able to give patients information about local services, help lines and support.

The department undertook multi-disciplinary debriefing sessions. These were held for staff if they had been involved in a distressing event with a patient. Counselling was available for staff if required. Team leaders confirmed they had training in debriefing staff and were able to sign post to other specialist support, such as Trauma Risk Management assessments. Trauma risk management aims to support individuals following exposure to significantly traumatic events or incidents.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24-hours a day, seven days a week. Patients were reviewed by specialist consultant teams depending on the care pathway seven days a week. The frailty team worked from 8am to 6pm, five days a week, but were planning to extend this to a seven day service. The department was supported at the weekend by physiotherapists and occupational therapists/therapy assistants.

The service had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs, including outside office hours.

The emergency department had an X -ray service within the department which was available 24 hours a day seven days a week. Staff were able to book an X -ray online and the waiting time was dependent on the urgency and

volume of work to be done. Staff also told us that they could access the CT scanning service at any hour of the day or night. This was also booked on line and again the waiting time was dependent on the urgency and volume of work to be done. Radiology staff would move between both CT and X-ray at night.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in the department. In the waiting area, there was a board with alcohol awareness information, which included; where to get advice, effects of alcohol use and what are units of alcohol. There were various leaflets available for people regarding health care such as diabetes. We saw that when people were discharged, they were also given information to self-care at home, for example, taking care of a plaster cast.

Staff discussed the emphasis they placed on enabling patients to take control of and improve their health. They described this being particularly important with vulnerable patients and the impact health promotion has with chronic diseases, mental health, physical activity and nutrition, for example.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 (amended 2004) and they knew who to contact for advice. Staff in the psychiatric liaison team told us that the staff in the department had a good understanding of the Mental Capacity Act 2005 and would contact the team if they needed advice or support. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

A breakdown of compliance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) training courses as at 31 December 2019 for qualified nursing staff, showed the training target was not met for the one training module for which qualified nursing staff were eligible. The information showed 83.8% had completed the training against a trust target of 85%.

A breakdown of compliance for MCA and DOLS training courses as at 31 December 2019 for medical staff showed that the target was not met for the one MCA and DOLS training module for which medical staff were eligible. The information showed 50% had completed the training.

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

Staff gained consent from patients for their care and treatment and when patients could not give consent, staff made decisions in their best interest. Staff clearly and consistently recorded consent in the patients' records.

We spoke with ten members of staff who were able to tell us the actions they would take if they had concerns about an individual's mental capacity. Staff working with children and young people were knowledgeable about the concept of Gillick competence and Fraser guidelines. They were aware of the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated enough maturity and intelligence to do so, often referred to as being Gillick competent. Staff were aware that should a child not be considered "Gillick competent", consent would be sought from the child's parent or guardian. Staff could also describe the scenarios in which an individual would be deemed to have parental responsibility.

Staff had mandatory Mental Health Act and Mental Capacity Act training. They also had dementia awareness training. The department could access staff that were qualified mental health nurses and booked an agency registered mental health nurse if needed. The trust has also started training staff in mental health awareness and one member of staff showed us the training they had completed and how they used those new skills when caring for patients in the department.

Requires improvement

Urgent and emergency services

Are urgent and emergency services caring?

Good

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

Compassionate care

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

Throughout the inspection we observed staff speaking in appropriate ways with patients. Staff adapted their body language to enable them to communicate more effectively with patients. For example, we observed a consultant lower themselves to their knees to enable them to make appropriate eye contact with a child. We observed an episode of care during which staff were speaking to an unconscious patient; this was despite the patient not being able to respond.

Most staff used curtains around the bed spaces to provide privacy when assessing and treating patients and ensured patients' dignity was maintained when curtains were opened. Patients were covered up at all times when they were in the department and when patients were transferred. However, the triage area had a curtain to protect patient dignity however, this was not always used. There was a private room for patients requiring more intimate procedure such as electrocardiograms which require patients to remove some of their clothing.

When patients arrived in the department staff introduced themselves with "Hello my Name is", they explained what would happen next, this was a consistent and embedded practice across the department. The porters also spoke with patients and their relatives in a kind and considerate manner.

Reception staff were observed providing reassurance to patients when they presented to the reception desk. Reception staff prompted other patients and relatives to step back from the reception when other patients were being booked in; this ensured the privacy of patients.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had received training in breaking bad news as part of their trust induction. They were able to access additional guidance through the trust intranet. Staff were also able to access the relative's room on the main department where they could sit with relatives or allow relatives to sit quietly.

We observed episodes of care during which patients were truly respected and valued as individuals. Patients were empowered as partners in their care both practically and emotionally. This was especially the case for those patients who presented with mental health conditions or those patients who were recognised as vulnerable. Staff de-escalated anxious patients through non-physical techniques. Members of the vulnerable adult support team had been trained to use motivational interview techniques; this technique enabled staff to help patients to change or alter their behaviour by helping people to overcome ambivalence about a particular course of action.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The location of the mental health assessment room assisted staff keeping the patient and staff safe and they worked closely with the police who used the rooms as a place of safety for patients with mental ill health.

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, learning disabilities, autism or dementia.

Understanding and involvement of patients and those close to them

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

Requires improvement

Urgent and emergency services

Staff made sure patients and those close to them understood their care and treatment. Patients told us that staff asked their consent before completing observations and blood tests. We spoke with patients who told us they were aware of the plan for their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients told us that they felt able to raise concerns if they had them. However, no one had felt the need to make a complaint although they had to wait staff kept them informed of what was happening.

Staff supported patients to make informed decisions about their care. Staff asked patients open questions to help make assessments. Patients were being told what had happened and what was going to happen in their treatment. Staff gave patients an opportunity to ask questions and have input into their care.

Most patients and relatives we spoke with felt well informed of what was going on with their care, and believed they had an input into care decisions. However, one patient told us they didn't know what was happening next. We raised this with staff who went to the patient and explained what was happening with their care.

We spoke with the discharge team, they monitor the department regularly for referrals and can also get calls from staff. They review the patient's mobility and their equipment needs. For example, we spoke with a relative of a patient who had fallen, they described their involvement and that of the patient during their treatment in the department. The patient had come into the emergency department via ambulance. The patient was moved quickly into the observation ward following an X-ray and was seen by the discharge team, shortly after they got to the observation ward. At 1:30pm the relative was taking equipment out to the car, given to them by the team, with a plan for the patient to be discharged home that afternoon.

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 met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service was accessible and sign-posted from the main road and the main hospital entrance. There was suitable parking (including disabled parking) close by. Signage was also available throughout the hospital which helped visitors find their way to the department.

The large reception area at the front was clearly visible for visitors. Waiting areas were large and had enough seating for patients. Vending machines containing a range of foods were available and well stocked.

Reception desks had been designed so they were accessible for patients in wheelchairs.

Facilities and premises were appropriate for the services being delivered. The department access was the same for all patients. When adult patients booked in, they waited in the chairs for further assessment. From the waiting area, patients were streamed to specific pathways depending on the clinical need of the patient.

Patients under 18 years of age were taken into the paediatric and young person area. The department was staffed with two registered nurses and a health care support worker, with support from the paediatric wards on some days. The paediatric unit was locked with secure electronic access. The unit had close circuit television in the waiting area so staff could monitor patient's wellbeing whilst they waited to be seen.

The resuscitation area had three adult beds and one for paediatric and young people. This had been equipped and had been designated as a child and young person only bay since the last inspection.

The ambulatory care unit was staffed by nurses and health care support workers with a senior nurse overseeing the unit.

The department accessed an interpreting and translation service for those whose first language was not English or where patients required a British Sign Language interpreter.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia.

In response to an ageing population, the department had introduced a dementia champion who worked to raise awareness of those living with dementia and were available to offer advice and support to staff, patients and carers during their time in the department. There was a "forget me not" system in place which alerted staff to patients who may be experiencing memory problems or confusion. Staff knew to allow more time for these patients when speaking with them and helping them to understand what was going on. They also said they offered additional support with tasks where needed; for example, with eating, drinking, going to the toilet and being accompanied to different departments across the hospital.

Patients with an identified learning disability were flagged on the electronic system. Triage nurses told us they could place prompts on the electronic system if a patient with learning disabilities presented to the department and who was not previously known to the trust. There was a process to fast-track specific vulnerable patient groups through the emergency care pathway so patients remained in the department for as little time as was clinically required.

The department had access to a psychiatric liaison team who were able to attend the department within four hours. Staff told us there was a dementia liaison team but that this was only available during the day and not out of hours. Staff had to call children and adolescent mental health team in the community to assess patients. Staff reported that they completed a triage form and then emailed a referral form to the community team.

There was a poster displaying nursing uniforms. This gave patients a way of identifying those who were caring for them. Staff wore 'My name is' badges, so patients and relatives could see the names of staff.

Doctors would sometimes request a nurse be present in the cubicle and would ask the patient permission for a chaperone to be present. There was information telling patients chaperones were available.

A play specialist was based in the paediatric emergency department. The team told us the support was very useful when the unit was busy. We noted that children in the paediatric unit were able to play with toys in the waiting area. There was a television and films available to occupy patients waiting.

Access and flow

Not all people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards but had improved since our last inspection.

Managers monitored waiting times and made sure patients could access emergency services when needed and receive treatment within agreed timeframes and national targets. There was no visible waiting time displayed in the main waiting area. Administration staff would tell patients waiting in the reception area of an estimated time to be seen. The reception area had an initial assessment area.

Staff responded to pre-alerts where the team received advance warning of patients who were very unwell via a telephone which was situated in the main department. We observed doctors and nurses answering it and planning for the patient arrival. The electronic system also alerted staff to the ambulances that were inbound so they could prepare for staff to meet them for the handover.

Requires improvement

Urgent and emergency services

Managers and staff worked to make sure patients did not stay longer than they needed to. During this inspection, we saw the electronic system that tracked the time each patient was in the department. Each name had a symbol that alerted staff when the patient had been in the department for two hours, three hours, close to breaching at four hours, breaching the four hour target, six hours and longer than six hours. Each symbol was easily recognised by staff. Patients names changed colour as they were seen by clinicians. This meant that staff were able to identify patient progress through the department at one glance.

We attended two of the two hourly meetings led by the senior staff on duty. The meeting involved staff verbally reporting on the number of possible discharges and what support was needed from other areas such as occupational therapy assessments. This assisted with the flow of patients through the department.

Out of hours mental health provision was available for both children and adults. Psychiatric liaison and child and adolescent mental health teams worked towards their own performance indicators and had established new mental health triage systems to respond in a shorter time. During normal working hours this response time was routinely achieved however there was an acknowledgment amongst staff that more work was required for those patients who presented out of hours. In most instances staff said patients who required a Mental Health Act assessment were assessed by an Approved Mental Health Practitioner (AMHP) and Section 12 doctor with minimal delay during the day time. However, staff said out of office hours there could be delays. Delays were also experienced whilst waiting to access an acute mental health bed.

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)

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.

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.

Learning from complaints and concerns

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

Staff we spoke with were aware of the complaints process should someone wish to complain. The management team took complaints seriously. We saw examples of learning from complaints being shared with staff to help improve the service for others. Outcomes were shared so that other staff could learn from the experiences of patients and their loved ones. We saw action plans developed to ensure actions were properly recorded.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw patient information leaflets in the department on how to contact the patient advice and liaison service or the complaints team.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to manage concerns from a patient and how to discuss their complaint. We spoke with six staff members who told us that they knew how to manage complaints in the department. All the staff we spoke with told us they would try to manage the complaint and then discuss with the nurse in charge or doctor if it related to patient care. Staff would document when they had explained the care being given.

Urgent and emergency services

Managers investigated complaints and identified themes. We reviewed five complaints, their responses and actions plans which had been developed in response to the investigations carried out. Complaint responses were candid and detailed. Each point raised by the three complainants were investigated. Complaint responses were neither defensive nor critical of the patients' experience. Various health professionals were involved in the investigation of complaints which ensured responses were of a multi-disciplinary nature. Actions were appropriate to the issues identified. Action plans were created and monitored to ensure all relevant actions were instigated.

Staff were made aware of complaints and any themes as part of team meetings. For example, patients had complained about being cared for in the corridor instead of a bay area. The care of patients in the corridor and the department had improved by all disciplines reviewing all of the patients every two hours. This meant that bed management had improved, and patients waited for less time in the corridor and the corridor was only used as a last resort.

Are urgent and emergency services well-led?

Good

Our rating of well-led improved. We rated it as **Good.**

Leadership

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

The team structure for the emergency department consisted of a matron who oversaw all the hospital's emergency departments and a deputy matron who was based at the hospital. There were nine teams, each led by a band 7 nurse, with two band 6 nurses, three band 5 nurses, one band 4 and one band 3 member of staff. Domestic staff were also allocated to a team.

Within nursing teams, there were several link nurses to lead on giving advice to colleagues for specific groups of patients. There were link staff for infection prevention and control, dementia, mental health, diabetes, adult safeguarding, falls, sepsis, learning disabilities, respiratory, health and safety as well as speciality link staff.

Leaders within the urgent and emergency care service understood and told us about the challenges that the department faced. All senior staff seemed passionate about delivering high quality care to patients, whilst supporting other operational staff to achieve this. The matron was well regarded amongst the whole of the emergency department team.

At the start of each shift, staff were allocated to specific areas in the department. Senior nursing staff maintained regular oversight of demand in the department throughout the shift to best place staff in areas of high demand.

All staff we spoke with described the local leadership team as, supportive and visible within the department. During our inspection, we saw the local leadership team maintaining a visible presence and assisting at times of high demand. The local leadership team were located within the department, which allowed them to have oversight of all areas. There were clear escalation processes, which aimed to provide a consistent approach in times of pressure.

Consultant leadership in the department was committed and demonstrated clinical ownership of the patients in the department. Consultants had oversight of the department and had an awareness of who was the most unwell or had the potential to deteriorate.

The trust had introduced a CESR program in emergency medicine. CESRstands for Certificate of Eligibility for Specialist Registration. It is the route to specialist registration for doctors who have not completed a General Medical Council approved programme but who are able to demonstrate that their specialist training, qualifications, and experience are equivalent to the requirements for the certification of completion of training award. This had improved recruitment of doctors at middle grade level and allowed the trust to develop doctors that had the skills necessary to provide top level emergency care for patients.

Requires improvement

Urgent and emergency services

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

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 was underpinned by the values:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect is at the heart of everything we do
- People feel confident we are making a difference

The emergency department was developing its own vision and strategy. Part of the vision was recruitment of staff. There was difficulty recruiting, but there were regular recruitment drives. The children and young people's service put a business case forward for a practice development nurse to support a rotational post in their department, which will aid recruitment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

This was an honest and open department who knew the struggles that they faced but appeared united in sharing common themes about their concerns for the safety and facilities available for their patients. The leaders had open discussions with staff and there was a positive culture despite their challenges.

Staff spoke positively of the investment in their career development by offering good training packages and doctors praised the calibre of nursing staff, associate practitioners and nursing assistants. All staff we spoke with felt they were treated equally, and they did not feel disadvantaged through culture or diversity. The service had a "Star of the month", which recognised individual staff, nominated by their peers and leaders.

We observed staff working well together and helping each other in an open, friendly but professional manner. Different disciplines worked alongside each other and showed respect for each other's opinions. Discussions with staff revealed their enthusiasm and motivation for working in the department. For example, a member of the governance team regularly attended the department after her normal working hours and provided patients with snacks and sandwiches. Staff also told us the patient advice and liaison team, regularly attended the department and assisted with patient comfort issues, such as providing additional pillows and drinks.

Staff knew how to raise concerns and were confident they would be dealt with appropriately. Staff we spoke with were aware of the role of the trust's 'Freedom to Speak Up Guardians' and how they would access them if required.

The culture was positive and inclusive at local level but there were frustrations at senior level. Staff were keen to improve their department but worried that they were not always heard by the trust leadership team. For example, the team had piloted a new model of rapid assessment in the department. They had demonstrated this would mean patients would be seen by a senior clinician quickly and improve flow within the department. Staff were ready to implement it but were waiting for senior management to agree the model.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The emergency department had a team dedicated to governance issues, who led on the management of incidents, complaints and audit. They told us they felt the incident reporting culture within the department was a good one.

The team leader reviewed all incident reports received each day and requested further information from leaders

as required, whom with there was clearly a good working relationship. Additional information could also be reviewed on the electronic patient record. The governance manager then tracked all incidents and followed up on any outcomes to identify themes and trends. If an incident looked to have caused moderate harm, it was taken to a serious incident panel which was held weekly. The panel reviewed all information and if a serious incident was declared, a panel was allocated to investigate the incident. Once an incident was declared, patients and their carers were informed and invited to be included in the investigation and outcome. Staff gave us an example, where a family did not want to be involved in the investigation but wanted to be informed of the outcome. They requested that they were not informed by letter, so staff invited them in to discuss the outcome with them. There was a quality assurance process associated with serious incident reports, via the serious incident panel and corporate governance team, who would sign off all serious incident reports.

There were weekly urgent and emergency care governance and delivery meetings that monitored the issues that fed into the monthly governance meetings.

The governance team picked up themes and trends and looked and identified any areas for improvement. For example, if there was an increase in falls, the falls team would provide additional training. This was shared at the department's quarterly learning events.

Managing risks, issues and performance

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

All the risks on the risk register provided to us had been reviewed within the last 12 months. Actions put in place to mitigate the risk had been reviewed and updated regularly. Staff had a good understanding of the process of raising a risk. If they identified a risk, they would share this with their line manager, and it would get escalated for consideration to go on the risk register.

Senior nursing and medical staff met weekly. Each meeting had meeting minutes and included a separate action log for actions arising from the meeting. This meant any actions arising from the meeting had a staff member responsible for ensuring the action was undertaken. We reviewed three meeting minutes and saw they followed a set agenda and included key topics such as incidents, policy updates, requirement and audits.

Patient safety alerts were displayed within the department and visible to everyone.

There was a structured education pathway for all nurses and associate practitioners. This meant staff had the relevant training and skills to undertake their role.

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 structured in a way to clearly demonstrate an improvement in outcomes.

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 of the national targets.

The patient tracking list enabled leaders to monitor performance in real time. Staff could describe the escalation process for times of increased demand.

Managing information

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

Staff accessed patient information using an electronic system. However, some paper records were still used for specialities outside of the emergency department, but this was due to change with the introduction of a new electronic records system. Information technology systems were used to track patients through each journey in the emergency department. When patients booked into reception, they were booked onto the patient tracking list system. Staff could track a patient's progress

through their emergency department journey. Staff could to see what area patients were in, what team they had been referred to, what investigations had been undertaken and when investigation results were available. The nurse in charge had a good oversight of the whole department.

The nurse in charge was supported to manage the patient tracking list by flow coordinators. This post was a more recent addition to the team at the time of inspection. They monitored patient waiting times and escalated this to the nurse in charge and to the general manager for further action. The trust used an electronic flagging system to identify patients who were vulnerable or those who were living with complex needs. Each area of the emergency department had access to the patient tracking list.

The trust's intranet had policies that were easy to access and subdivided into directorates and departments.

During our inspection, we did not see any occasion when patient records with confidential information were left unattended. In the observation ward, patient records were kept in a locked trolley. Staff locked and secured computer terminals in all areas when not in use.

Engagement

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

Staff told us they had a good relationship with the local ambulance service. They received a high number of patients by ambulance, staff trusted the ambulance crews' clinical decisions on who they conveyed into the hospital. They had worked with the trust to reduce ambulance handover times. Staff had a weekly meeting with the local mental health trust and local ambulance trust about frequent attenders to the emergency department, to discuss management plans.

The department shared a quality improvement newsletter for staff in the emergency department. It shared patient feedback, learning from incidents, performance data against national standards, medicines safety bulletins and audit results.

The emergency department team had a quarterly meeting, for training and sharing learning. Food and refreshments were provided for staff and they told us, the events were well attended and essential for sharing information and engaging with colleagues.

The trust had introduced an electronic, self-rostering yearly rota for the emergency departments middle grades with staff numbers and shifts based around emergency department activity. This has improved emergency department performances whilst improving staff morale, recruitment and retention.

A formal training program for advanced clinical practitioners in acute care, had been introduced and the first cohort was due to be accredited in the next 12 months. We spoke with staff on the programme who told us the introduction of the program had made them feel valued members of staff and encouraged them to remain in their posts in the trust.

Patients could complete the friends and family test by text message or on the trust's website. Patients could provide feedback on whether they would recommend the service in a variety of methods, which suited their needs or convenience. The trust's website enabled service users to leave general comments on how they might improve their service, leave compliments, complaints or concerns.

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.

Some staff members wore a badge that stated, 'New Member of Staff'. This proved useful in a busy and large department when supporting staff on shift and saved the new staff member from being asked to do things that may be out of their remit at that time. It also enabled staff to show them something of interest or observe a procedure.

The trust had implemented an electronic patient tracking list linking the ambulance trust inbound ambulance screen. This gave staff alerts to ambulances exceeding

maximum waiting times to offload. It was linked to the trust patient administration system and alerted staff prior to arrival, of any dementia flags, care plans and frailty score.

The trust had introduced a computed tomography tracking board in the emergency control room which gave the information for all outstanding diagnostic scans in the department. This system also allowed electronic communication between the diagnostic service and the emergency departments, reducing phone calls.

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.

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 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 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

Action the provider SHOULD take to improve

- The trust should consider how to recruit a full establishment of emergency department consultants.
- The trust should ensure all medicine records are completed when medicines are administrated or detail why they have not been given.
- The trust should ensure medicines reconciliation is undertaken in a timely manner.
- The trust should consider how to improve privacy and dignity of patients while being triaged.

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