The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at The Princess Alexandra Hospital

Requires Improvement 

The Princess Alexandra Hospital NHS Trust provides acute and specialist services. The main site is the Princess Alexandra Hospital (PAH), which is a district general hospital. The trust has 2 satellite sites Herts and Essex Hospital and St Margaret's Hospital.

The trust has 418 acute inpatient beds, 10 critical care beds and 46 maternity beds. They currently employ a total of 2,147 staff, of these 1,265 are nursing and midwifery and 557 are medical across the trust.

The total number of inpatient admissions for PAH from March 2021 to February 2022 totalled 57,349. From March 2021 to February 2022 there were a total of 28,031 A&E attendances, of which 7,128 were children. Of all A&E attendees 18.4% arrived by ambulance.

The PAH was built in the mid 1960's, and the building is showing signs of age and there is very little room for expansion on the current site. The trust is part of the nationally led New Hospitals programme and the Government announced it is to receive funding to rebuild a new hospital in Harlow.

We carried out this short notice announced focused inspection of the emergency department (ED) at PAH on 29 March 2023.

The service was rated as inadequate following our previous inspection, published in November 2021. Following the last inspection, we issued an urgent notice of decision under Section 31 of the Health and Social Care Act 2008, to impose conditions on the trusts in respect of the regulated activity Treatment of disease, disorder or injury related to the core service of Urgent and Emergency Care services. We carried out this inspection to determine if improvement had been made against the conditions imposed.

The following conditions imposed in 2021 were:

The Registered Provider must ensure there are sufficient numbers of suitably qualified, skilled, competent and experienced nursing staff at all times to meet the needs of patients within all areas of the Emergency Department at the Princess Alexandra Hospital

The Registered Provider must operate an effective system which will ensure that every patient attending the Emergency Department at the Princess Alexandra Hospital has an initial assessment of their condition to enable staff to identify the most clinically urgent patients and to ensure they are triaged, assessed and appropriately streamlined

The Registered Provider must devise a process and undertake a review of current and future patients clinical risk assessments, care planning and physiological observations, and ensure that the level of patients' needs are individualised, recorded and acted upon. This must include, but not limited to skin integrity, falls, and mental health assessments

Our findings

The registered provider must ensure that it implements an effective system with the aim of ensuring all patients who present to the emergency department at the Princess Alexandra Hospital patient observations are completed within 15 minutes of arrival and as appropriately thereafter in line with trust policy.

We inspected the urgent and emergency care at PAH. This was a focused inspection and therefore we looked at the key questions safe, responsive, effective and well-led. We carried out this inspection to determine if improvement had been made against the conditions imposed in 2021.

Our rating of this location improved. We rated it as requires improvement because:

- The service did not always have enough staff to care for patients in all areas to keep them safe.
- Staff did not always complete risk assessments for each patient in a timely manner.
- Staff did not always keep contemporaneous care records.
- People could not always access the services when they needed them and waiting times for treatment was consistently worse than the national average.
- Patient follow up observations were not always completed in line with trust policy.
- Pain relief was not always offered in a timely way.
- Leaders did not always provide effective risk mitigation.
- The service's governance processes did not always ensure effective patient flow and risk mitigation.
- The service did not have a robust streaming system to match patients to the most appropriate service.
- Call bells were not always in reach of patients.

However:

- The service had made improvements since our previous inspection ensuring that those with mental health conditions received appropriate care and treatment.
- The service had implemented a nationally recognised triage tool.
- All patients received an initial set of observations in line with trust policy.
- The service made sure staff were competent for their roles.
- The service was inclusive and considered individual needs and preferences.

We inspected the emergency department (ED) including minors area, majors area, the further assessment unit, resuscitation area (resus), rapid assessment and triage (RAT) area and paediatric emergency department.

We spoke with 25 members of staff including service leaders, nurses, doctors and healthcare assistants and 6 service users.

We observed care and looked at care records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments and audit results.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Environment and equipment

At our previous inspection we found that the use of premises and equipment was not keeping patients safe. During this inspection we found the service had made improvements to the environment including the mental health rooms. However, we found that patients still did not have access to call bells and that the lack of space in the services Rapid Assessment and Treatment area was impacting flow.

The emergency department (ED) had a capacity of 100-120 patients (including the urgent treatment centre (UTC)) comprised of several areas; reception, majors 1 and 2, resus, rapid assessment and treatment (RAT), further assessment unit and paediatric ED.

Staff reported the lack of space in RAT impacted on the ability to maintain a flow that met the demand on the service at certain times of day. During inspection we observed delays in the RAT process were attributed to a lack of space, this limited ambulance offloading. This meant that patients were not seen within the national guidelines Royal College of Emergency Medicine (RCEM) guidance 'Initial Assessment of Emergency Department Patients' (2017). Trust target to complete the RAT process was 15 minutes which was not achieved for all patients we observed during inspection.

We observed 4 patients during the RAT process. It took on average 15-20 minutes to complete the triage and rapid assessment process, exceeding trust policy. One elderly patient was delayed by 30 minutes in RAT due to a lack of space to move into a cubicle in the ED. There were a further 8 ambulances queuing but the lack of flow within the department and lack of space within the RAT area meant patients were waiting in the ambulance for assessments.

The further assessment area had 16 seats and an assessment area with 2 trolley cubicles next to the seated area. This area was formed to allow greater capacity and oversight of ambulatory patients whom require majors level care following the triage process and facilitated flow from the front door. Criteria for admission to the further assessment unit whilst awaiting medical review and treatment was displayed clearly for all staff.

The paediatric department was in a separate area of ED. It had a separate entrance and waiting area from the adult section. Entrance to the paediatric department was by swipe card or buzzer with CCTV and exit from the department was by swipe card only, this ensured the safety of the children. Paediatric ED had 6 cubicles and a high dependency room which was equipped for resuscitation of children. The paediatric clinical decision unit (CDU) had trolley cubicles and allowed for review by a clinician and wait for a maximum of 12 hours in the department to complete observation/ treatment.

Urgent and emergency services

At our last inspection in 2021 we found the room used for children who presented with mental ill health was not fit for purpose. The room was out of the line of sight of nurses, was full of equipment and did not have an emergency call alarm system. We took enforcement action against the trust in the form of a requirement notice, under Section 31 of the Health and Social Care Act 2008, to ensure the paediatric mental health room is fit for purpose and meets the standards set out in Facing the Future, Standards for Children in Emergency Care Settings. (Regulation 13).

During this inspection we found a series of improvements with the trust's adult and paediatric mental health rooms. A panic bar had been installed around the perimeter allowing for quick access in the event of an emergency. Mental health rooms were equipped with soft furnishings and a mirror to ensure full visibility to reduce risk. Ligature cutters were stored securely within easy reach of the rooms. The toilet and shower room used for mental health patients were fully risk assessed and ligature free. We were assured both adult and paediatric mental health rooms for fit for purpose.

During the previous inspection patients could not always reach call bells and staff did not always respond quickly when called. We did not find improvements in this area on inspection. We observed 10 out of 13 call bells were still in the holder on the wall within majors 1 and 2. Five of these patients were alone with no family or staff member by their bedside. This meant that they could not call for help or assistance if needed.

At the previous inspection the bin for disposal of contaminated personal protective equipment (PPE) was inside the Aerosol Generating Procedure room and staff told us they removed their PPE in the room. This meant that staff were potentially exposed to airborne particles once they had taken off their PPE. AGPs are treatments where infectious material can become airborne and requires a higher level of PPE for staff. During this inspection we found the disposal bin was outside the door, however there were 2 bins inside the room. There was visible guidance for staff on how to safely apply and remove PPE. There was no patient in the AGP room at the time of inspection so did not observe how staff carrying out the process.

Assessing and responding to patient risk

The service had made improvement since our previous inspection including implementing a nationally recognised triaging tool and ensuring those presenting with mental health conditions received the appropriate care and treatment. However, patients were not always triaged within the trust's target timeframe and observations and risk assessments were not completed in line with policy.

At our previous inspection in 2021, it was identified that there was no validated system in place to recognise critically unwell patients arriving at the front door or via ambulance to ED. Previously a registered nurse (RN) and a health care assistant (HCA) used patient symptoms and clinical observations to stream patients when they self-presented at ED. This resulted in enforcement action in the form of conditions of registration because the quality of healthcare required significant improvement. The trust had to ensure an effective system was in place to enable staff to identify the most clinically urgent patients and to ensure they are triaged, assessed and appropriately streamlined (Regulation 12). During this inspection we saw some improvements were made against this condition.

Staff completed a screening tool for each patient on admission/arrival, using a recognised tool. The service had improved since the previous inspection. Staff used the Manchester Triage System (MTS) to safely manage all patients presenting to ED. We were assured that nurses assigned a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis.

However, patients were not always triaged within the service's target of 15 minutes. At 8.00am 5 patients were triaged within 15 minutes, in line with policy. At 10.30am we saw 10 patients waiting to be triaged by a single nurse, they had

waited for 30 minutes. At 11.20am and 1.03pm we escalated delayed triage times in excess of 60 minutes to senior staff. We reviewed electronic patient records for timeliness of triage. An additional 3 out of 6 patient record we reviewed were not triaged within 15 minutes of arrival on the day of inspection. This meant patients were not always triaged in a timely way in line with policy.

The trust reviewed their own performance for time to triage. Audit data submitted by the trust for January 2023 to March 2023 showed on average 75% of patients were triaged within 15 minutes of arrival at the front door. This meant approximately 25% of all patients presenting in the department were not triaged in line with the Royal College of Emergency Medicine (RCEM) guidance 'Initial Assessment of Emergency Department Patients' (2017). The trust had plans to improve the performance relating to the target through the implementation of the supernumerary nurse in charge, escalation cards to respond to staff needs in a more timely manner as well as taking part in the NHSE Triage pilot on 1 May 2023 which looked at standardising triage across ED nationally.

There was a lack of robust streaming systems to match patients with the service most suited to meet their clinical need. We observed 10 patients waiting for triage at 10.30am with wait times exceeding 30 minutes, this increased to over an hour at 11.20am. There was a lack of signposting upon arrival to the most appropriate service for patients. Patients who were referred by their GP were booked at reception and waited to be triaged. We found the service was underutilising their urgent treatment centre, same day emergency care and GP services which possibly added to the lengthy wait time for patients and crowding at the front door.
The trust meeting minutes for monthly urgent and emergency care performance review in March 2023 showed an action plan to address optimising streaming of lower acuity patients. The trust planned on reviewing the utilisation of UTC and SDEC, had planned to employ a clinical navigator to sign post specialty referral to alternative pathways reducing the number of patients attending ED and provide a single point of contact for GP referrals.

At 1.30pm we observed a full reception area, patients were queuing to register at the front door of ED with only 1 nurse triaging patients. This was escalated to senior members of staff at the time of inspection. We were not assured that the trust had a robust system to appropriately streamline patients making use of all services available as per national guidance by Royal College of Emergency Medicine (RCEM) guidance 'Initial Assessment of Emergency Department Patients' (2017).

Following the inspection, the trust implemented a triage work stream to review and refine the current process in response to our inspection feedback. Senior leaders told us they had developed escalation triggers and action plans to address concerns.

The hospital ambulance liaison officer (HALO) who was a member of staff based at the trust but employed by the NHS ambulance service, liaised with the nurse in charge and the ambulance crew regarding patients waiting for RAT. We were assured that they had full oversight of all patients waiting and prioritised those deteriorating and needing urgent medical care.

Staff told us that during busy times, up to 4 patients would wait for assessment in the corridor. Once assessed patients would be moved back onto the ambulance with ED staff carrying out observations and any further treatment on the vehicle if there was no space to accommodate them in the ED. Staff reported the lack of space and flow impacted on the effectiveness of RAT to meet the fluctuating demand over a 24 hour period.

Urgent and emergency services

Children attending ED were booked in at paediatric reception, a wrist band was printed and placed on arrival. Children under the age of 6 months or arriving by ambulance were streamed by a paediatric registered nurse. During the streaming process a set of initial observations were taken and recorded. All children were triaged using the MTS in line with best practice. Staff reported they did not always triage within 15 minutes of arrival as per guidelines and this was observed on inspection.

Two parents we spoke to within the children's ED commented on staff being friendly and helpful but had waited in the department for 3 hours . One parent was informed of the plan but the other was transferred from the UTC and was not informed of how long the wait would be.

Children presenting with mental health crisis were booked in reception and triaged in line with trust policy. Risk assessments and doctor reviews were completed prior to referral to child and adolescent mental health service (CAMHS). However, new NICE guidance supports early referral to CAMHS without a doctor review. Staff reported patients waited at least 40 minutes for the CAMHS crisis team.

The trust provided information about the placement of children and adolescents who required inpatient mental health care were supported through the provider collaborative. The children and young persons mental health liaison nurse reported joint working with CAMHS to share learning with staff. However, staff reported that children often waited days and weeks for mental health placements. During inspection there was a child with mental health needs that had waited for 2 days in ED before being transferred to the paediatric ward.

During inspection we were informed medication prescription was delegated to the specialty teams. This meant patients identified at high risk of developing a venous thromboembolism (VTE) upon completion of a risk assessment in ED would need to await review by the accepting specialty team to prescribe VTE prophylaxis medication. A review of medical notes for an elderly patient in the department showed VTE prophylaxis was prescribed 12 hours after presenting to ED, having been identified as high risk during screening. We were not assured that the service was managing the risks around VTE in a timely manner.

The trust did not have patient group directives (PGD) within ED. PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This meant patients were waiting for timely administration of medications in ED. Following inspection, the trust reported developing 19 PGDs, 16 had been reviewed and 3 were to be reviewed by the trust policy group.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff knew how to make an urgent referral to them and received a timely response.

At our previous inspection we identified that patients presenting with mental health concerns were not provided with the care and support identified in their care plans. This resulted in enforcement action in the form of conditions of registration because the quality of healthcare required significant improvement. The trust must ensure current and future patients clinical risk assessments, including mental health, and care plans were recorded and acted upon. The service had significantly improved their response to mental health patients presenting in the emergency department.

The trust placed a registered mental health nurse (RMN) on every shift, 24 hours a day, within ED to mitigate risk to patients presenting with a mental ill health crisis. The trust had a pool of 4 RMN's who cover day and night shifts with short notice sickness covered using enhanced care staff with mental health training. Additional staff were provided to support the RMN in the event of multiple high risk mental health patients in ED, this need was reviewed throughout the

day. Daily mental health risk assessments were recorded every morning on the services patient record system to identify those at high risk and need for more staffing to maintain safety. All patients presenting to ED were screened for mental health risk, the RMN completed full mental health risk assessments in a timely manner, if triggered following the initial screening tool. If a patient required 1-to-1 care this was provided by the RMN.

We were assured that the trust completed mental health risk assessments for all patients presenting with or had a history of a mental health crisis to mitigate any risks to patients and staff safely. The most recent documentation audit data provided by the trust for January to April 2023, showed 100% completion of mental health (MH) risk assessments. We saw on inspection that care plans was fully completed and implemented for 2 patients in ED in line with trust policy.

Since our previous inspection the service had implemented a new role in the children's emergency department of children and young people (CYP) mental health liaison nurse to oversee the care of children presenting with mental health concerns. The CYP mental health liaison nurse currently worked during weekdays. The trust had appointed another CYP liaison nurse, with the intention to provide a 7 day mental health liaison nurse within the children's ED.

Staff told us that a child presenting with mental health ill crisis in the department would have a health care assistant allocated to be with them at all times. Staff told us they complete mental health risk assessments for CYP. However, no audits to assess compliance had been carried out at the time of inspection. We were informed that compliance was being monitored by CYP mental health liaison nurse but we were not provided with data for this.

Staff used a nationally recognised tool to identify deteriorating patients. However, patients did not always receive timely observations meaning we could not be assured deteriorating patients were always escalated appropriately. The hospital introduced an electronic record system to record both clinical observations and risk assessments. This was implemented in July 2022 across the emergency department. The new system monitored and analysed observations automatically alerting to a worsening condition through a colour coded system.

Staff used the National Early Warning Score 2 (NEWS2) scoring system to monitor patients and identify those requiring escalation upon arrival to ED. A NEWS2 score greater than 3 indicated the need for hourly observations in line with NEWS 2 guidance. At the last inspection data supplied by the trust January 2021 to July 2021 showed a NEWS2 compliance of 86%. During our previous inspection 7 patients had not received timely observations with gaps of between 3 and 5 hours. This resulted in enforcement action in the form of conditions of registration because the quality of healthcare required significant improvement.

We reviewed audit data submitted for January 2023 to March 2023 showed a compliance of 100% for completion and escalation, in line with NEWS 2 guidance for patients upon arrival to ED.

We found that whilst all patients received timely observations on arrival to the department, that follow up observations were not completed in a timely way in line with policy. We reviewed 12 electronic patient records and looked at observation monitoring. All 12 patients did not have regular observations completed in line with trust policy. Four patients with a NEWS2 greater than 3 had gaps of between 1.5 and 3 hours, not in line with NEWS 2 guidance. We escalated our findings to the practice development nurse within ED. We were not assured that the trust had sufficiently addressed our concerns regarding the timeliness of ongoing monitoring of patients in the ED.

Urgent and emergency services

A staff member told us completion of hourly observations was not always achievable due to a lack of staffing across ED. Observations for all ED patients should be completed hourly in line with trust policy. Overdue observations turn 'red' on the handheld electronic patient record device indicating the need for completion. Staff reported difficulty in identifying those deteriorating within the area from those needing completion of hourly observations as both turn 'red'. This meant that patients needing escalation of treatment may not always be identified in a timely manner.

Within the children's ED there was evidence of the use of Paediatric Early Warning Score Tools (PEWS) to monitor and identify children requiring escalation of medical treatment. All observations were also recorded on the electronic record system. During the inspection we reviewed records for 3 patients waiting in ED. All 3 patients were overdue their hourly observations, 2 were overdue by an hour and 1 patient who was identified as suspected sepsis was delayed by 20 minutes. Documentation of timely monitoring observations were not in line with trust policy. We escalated our concerns to nursing staff who ensured further observations were completed. Staff would escalate a deteriorating child in ED in accordance with policy. Staff reported that doctors are very responsive and timely when called on.

Staff did not always update risk assessments for each patient. Staff completed initial risk assessments for patients thought to be at risk of self-harm or suicide, falls and pressure ulcers on arrival. We observed 100% of patients being screened for initial risk. However, staff did not complete full risk assessments in a timely manner in line with trust policy of within 6 hours of arrival. The most recent initial risk assessment and care plan documentation audit data provided by the trust April 2023 showed a compliance rate of 86%. Of the 14% of patients that did not have a completed risk assessment, we saw no evidence of harm and these patients were discharged after 8 and 10 hours.

We reviewed 7 patient records for completion of risk assessments. Staff had completed full risk assessments for 2 patients in line with trust policy. Two patients did not trigger the need for a risk assessment completion and 3 patients did not have completed assessments for bed rails and pressure ulcers in line with policy. These patients had been identified as at risk during initial risk assessments at triage.

One patient had an identified mental health risk but did not have a full mental health risk assessment in place with documented mitigating actions. However, staff had mitigated the immediate ligature risk as they had placed the patient in a cubicle space near the nursing station so they always had sight of the patient. Staff had also referred the patient for specialist review. On the day of inspection the staff member reported not having time to complete the risk assessment documentation in a timely manner to reflect the actions taken and told us they would document in retrospect. We were assured that safety of the mental health patient had been maintained in this instance despite the lack of documentation and risk assessment.

Two patients had been identified at high risk of pressure ulcers. Staff had not completed a risk assessment or recorded comfort rounds on electronic record system after 7 and 10 hours, we escalated this to nursing staff at the time. Following the inspection senior leaders informed us that they reviewed the risk records of those patients. Leaders informed us that all nursing staff received feedback as well as training and education identified for specific individuals following our concerns.

We were not assured staff mitigated risk that was identified on admission for all patients. Staff did not always complete bed rail assessments for patients in line with trust policy. At 10.30am we observed bed rails up for all patients in majors 1. Bed rails are not suitable in all situations and may increase the risk of harm to patients such as entrapment and entanglement either within gaps in the rails themselves, between the rails and the mattress or between the rails and the bed frame. Staff had not completed bed rail risk assessments for all patients. One patient reported that the use of the

bed rails had not been discussed with them but were used by staff. A review of the bed rail policy stated staff should always, where possible, discuss the use of bed rails and advised completion of the risk assessments within 6 hours of admission. Two patients that required a bed rail risk assessment had been in the department for 7 and 22 hours without a completed assessment.

An audit was conducted from October 2022 to March 2023 looking at the compliance of bed rail risk assessments. Data showed an improvement in compliance overall following the implementation of the electronic record system. They had sustained a compliance of above 80% for the last 3 months and it remained a high focus for teams. However, this was not reflective of what we saw on inspection.

Staff shared key information to keep patients safe when handing over their care to others. We observed a structured approach to huddle meetings at 8.55am and 13.10pm. Staff discussed critically unwell patients, emergency calls overnight and escalated any issues. For example, discussions during the 8.55am handover highlighted the bleep system was not working overnight, this was immediately tested and patients who required immediate review were identified.

Nurse staffing

The service did not have enough nursing staff in all areas to keep patients safe from avoidable harm. Managers regularly reviewed staffing levels however they did not always redeploy staff to mitigate risk.

During our last inspection in 2021, there were occasions where the inspection team could not locate any nurses in the ED majors to assist them with urgent patient safety issues and the number of nurses and healthcare assistants (HCA) did not match the planned numbers. This resulted in an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, to ensure there are sufficient numbers of suitably qualified, skilled, competent and experienced nursing staff at all times to meet the needs of patients within all areas of the Emergency Department. Improvements have been made however there were times where we remained concerned around the numbers of staff available in certain areas to meet the demand and care for patients waiting in ED.

On the day of our inspection, the ED was below planned staffing levels for 2 registered nurses (RNs) due to short notice sickness and the service was unable to fill these with agency staff at short notice. Leaders told us staffing was amber on their RAG rating system in accordance to the safe staffing policy and considered the service staffing levels as safe as per the safer staffing tool. The trust reported using a RAG rating system for staffing against planned rotas. Red denotes less than 75% fill rate, Amber 76-95% and Green greater than 95% staffing. Training had been cancelled on the day of inspection to mitigate further impact on staffing in the service. Leaders told us that in the event of amber staffing, senior staff reviewed the demands throughout the day and redeploy staff from other areas and wards if necessary. However, on the day of inspection we did not see staff being moved from wards to fill the two RN shortfall and we observed the negative impact of the shortfall on the ability to meet the demand on the service.

During this inspection there were 2 occasions where the inspection team had to escalate delays to senior members of staff. One RN was working at the front door of the ED, at 11.20 10 patients were waiting for triage. Senior staff came to assist with triage once escalated. At 1.03pm we escalated the delays of 14 patients waiting for triage with 1 registered nurse in this area. We were not assured that there were sufficient staff numbers to meet the demand in the department.

Urgent and emergency services

At 1.27pm we observed 1 RN in resus caring for 4 patients, this had been escalated by the RN to the operational manager. The RN reported she was under pressure due to another staff member being on break. The RN on break returned after 30 minutes, no staff member was redeployed despite the escalation request support. We were not assured that there were sufficient numbers of suitably qualified, skilled, competent and experienced nursing staff at all times to meet the needs of patients within all areas of the ED.

Senior leaders reviewed the number and grade of nurses, nursing assistants and healthcare assistants at team huddles throughout the day. The trust held huddles at 8.00am, 11.00am, 1.00pm and 6.00pm. We observed senior leaders move a member of staff from further assessment unit to resus following the 11.00am huddle in response to a full resus. Staff did not always escalate to senior leaders when they required more staff in an area. We were not assured that staffing was adjusted in response to risk or delays in a timely manner.

However, there were enough paediatric nurses on shift with the right skills and qualifications to care for children in the paediatric emergency department. We were told that nearly all paediatric nurses were trained in emergency paediatric advanced life support (EPALS). We noted there were 2 EPALS trained nurses on shift during inspection, this was in line with Standard 13 of the standards for children in emergency care settings. A review of EPALS cover from January to March 2023 within the paediatric ED demonstrated compliance on every shift in line with the national guidance.

During the last inspection the paediatric department had a vacancy rate of 9 whole time equivalent (WTE) nurses and employed long term agency to mitigate risks to patient safety. At this inspection there was a vacancy rate was 7.2 WTE, the trust continued to recruit and had planned a recruitment day scheduled for May 2023 focusing on recruiting newly qualified registered paediatric nurses. Staff felt that managers had worked hard to improve recruitment in the department. A longstanding staff member reported improved staffing since the last inspection with effective use of permanent agency staff compared to previous years.

Within the main ED department there were 9 WTE vacancies at the time of inspection. Senior managers reported difficulty recruiting to more senior posts and were working towards a development programme to facilitate the promotion and growth of staff within the department. The service had 2 new nursing staff starting in May 2023 with a further recruitment day planned to fulfil the remaining outstanding vacancies.

Staff reported they escalated staffing concerns to the ED manager or senior staff. The ED matron met with managers from all areas twice a week to discuss staffing levels. The matron for children and younger persons (CYP) informed us that they walk round daily, conduct a monthly ED ward meeting to discuss staffing rotas, incidents, and performance against trust targets.

The supernumerary nurse in charge role for ED was implemented in April 2023 post inspection. The decision to appoint this role was following a review of the RCN Emergency Department Workforce Standards. This role provides overall oversight of the department, provide leadership and supervision to ensure safety and quality patient care across the entire ED day and night. The trust reported they were not allocated to a specific area in ED which allowed them to work in the capacity of a supervisory nurse in charge role and could provide direct patient care and staff support in a more timely manner outside of the structured huddles. However, the implementation of the supernumerary nurse did not come from an increase in the staffing numbers but from within the original staffing numbers on the unit. We did not observe the impact of this new role within the ED during inspection as it was not yet in place.

The service did not consistently meet the nursing workforce standards for ‘Type 1 Emergency Departments’ (2020) in October to December 2022. However, this improved from January to March 2023.

Urgent and emergency services

A review of trust data from October 2022 to March 2023 showed staffing levels did not consistently meet the target of an 80% fill rate for November and December. However, since January 2023 they had been fluctuating around 80% for qualified day shifts and 90% for night shifts.

A review of March 2023 data showed the trust only met their planned versus actual staffing for registered nurses for 2 days during the day and 12 days during the night. Data showed that the trust met their unqualified workforce planned versus actual staffing for the day shifts 11 times for the day shift during the month and 8 times for the night shifts.

The trust planned staffing in advance with arrangements in place for potential sickness, study leave and short notice annual leave.

Senior leaders considered staff redeployment from wards where actual staffing was between 75-95% of planned levels. We did not see evidence of redeployment on the day of our inspection despite the service being 2 RN's below establishment.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. However, there were often long delays in seeing a doctor and consultant cover was not in line with the Royal College of Emergency Medicine (RCEM) guidelines.

Consultant cover was not in line with RCEM guidelines which recommend a minimum of 16 hours cover as opposed to the 14 hours provided in the department. Medical staffing rotas were reviewed and demonstrated cover in ED from 8am to 10pm in 2 shift patterns 8am to 4pm and 1pm to 10pm. A consultant was on call from 10pm to 8am.

The trust was working towards increasing the number of consultants to 14 with the aspiration of employing a total of 16 ED consultants. This meant that there would be more consultants to provide direct clinical care, support of initial assessment processes, supervision of junior staff and have consultant cover to 16 hours in line with RECEM guidelines. A review of the ED risk registered showed a second business case had been completed in March 2023 to support the recruitment of 2 more consultants.

The paediatric emergency department had enough medical staff to keep patients safe. Paediatric consultant cover was available Monday to Friday in 2 shift patterns 10am to 6pm or 2pm to 10pm. There was a paediatric registrar 7 days a week, with cover provided by senior house officers supported by senior doctors. There was on call paediatric consultant cover for ED overnight. There was no paediatric emergency consultant employed at the trust at the time of inspection.

Paediatric medical staff fill rate did not always match against the planned number for April 2023. Fill rates were on average below 95% for 8am to 4pm and 1pm to 8pm shifts. These were mostly due to sickness, the trust mitigated risk by trying to fill with agency. Specialities and GPs from the urgent treatment centre (UTC) supported with direct referrals. The service also used additional staffing within overlapping shifts to support.

The trust reported using a RAG rating system for staffing against planned rotas. Red denotes less than 75% fill rate, Amber between 76 to 95% and Green greater than 95% staffing. From 23 March 2023 to 25 April 2023 staffing was categorised as red 14 times. However, due to some shifts being overfilled the overall average fill rate was maintained at 95% over a 24 hour period. The trust offered shifts out to agency, offered own staff more working hours and speciality teams were requested to take direct referral from triage if appropriate to keep patients safe.

There were 9.5 WTE vacancies at middle grade, recruitment offers to fill these vacancies had been made by the trust. Any gaps in the planned staffing were reviewed regularly and offered to NHS professionals, locums and own staff as additional shifts.

Since 16 January 2023 the trust commenced the trial of a new workforce model. This involved trialling an increase in medical staff from 27 to 31 over a 24 hour period. The original rota of 27 doctors did not allow for sickness, unexpected leave or the 2 hour mandatory medical teaching sessions twice a week; which had a significant impact on the department. In 2022 the guidance increased the mandatory training from 4 hours to 8 hours which further increased the shortfall in doctors. In January 2023 Since the increase early data suggested a reduction in long waits at night from 7.5 hours to less than 5. Senior leaders reported further analysis is required to ensure this was maintained.

In March 2023 data reviewed by the trust showed an average fill rate of 30 doctors over a 24 hour period. Senior leaders had planned to staff to a 'green' rota for 3 months and review the effectiveness against wait times to be seen by a doctor.

Where shifts were 'red' or 'amber' the operational teams would request support from the specialty teams to identify if a member of the team can be moved and based in ED to help see patients. If this was not possible the specialty teams would accept direct referrals from the streaming or RAT teams. This meant patients did not need to wait to be seen by an ED doctor before being seen by specialty teams. This was an effective way of reducing the ED workload when staffing was challenged and reduced the wait times within the department. The Emergency Physician In Charge (EPIC) would also link with the GP team who provide the on-site UTC service, and ensured that all of the appropriate patients are automatically streamed to the UTC.

Staffing concerns such as sickness, retention and overall workforce were discussed at various senior leadership meetings, medical staffing and recruitment were recorded in speciality meeting minutes dated 12 January 2023, 9 February 2023 and 9 March 2023.

The service had a good skill mix of staffing during inspection and senior leaders reviewed this regularly. Consultants were supported by a team of junior doctors with dedicated registrar doctors in ED from 8am to 5pm working in shift patterns that allowed for a 3 hour overlap. This overlap at consultant and registrar level allowed for comprehensive handover of information to reduce risk and allowed for movement of staff across all areas to meet the demand and support more junior staff on shift. Consultant shift scheduled hours allowed for an exit huddle before leaving at the end of the day, and any gaps in skill mix to mitigate risk to patients overnight.

Staffing reduced to 7 doctors in ED during the night including paediatric ED. Paediatricians worked collaboratively with doctors for support during this time. Staff reported delays of 7 hours some nights due to a reduced number of doctors in the department. Staff reported this led to frustration and abuse from parents waiting for reviews. Delays were further impacted on due to the closure of the Urgent Treatment Centre (UTC) at midnight. During the morning of inspection, the wait time to see a doctor was under an hour.

Trust reviewed the number of patients seen by a clinician within 60 minutes to monitor performance against internal professional standards. In April 2023 27% of patients were seen within 60 minutes of arrival, 28% of patients waited in excess of 180 minutes.

Urgent and emergency services

Staff and patients reported delays in doctor reviews after being triaged, wait times increased in the evenings due to reduced medical staff after 10pm across ED. Senior leaders reported that they reviewed the demand on the service against medical staffing in order to ensure the correct provision of cover over a 24 hour period. Registrars had access to consultant advice with overlap of shifts to ensure handovers were robust. The evaluation of handovers was due to be reviewed in May 2023.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were easily available to all staff providing care.

The trust used a combination of paper and electronic records in the ED. All observations and risk assessments undertaken were recorded on the trust's electronic patient record system which all staff had access to. During the inspection the electronic record system was not operational for approximately 15 minutes. We observed staff using paper records to record patient observations during this downtime. Staff stored paper records in secure trolleys at the nursing station so they were easily accessible to all staff.

During our previous inspection in 2021 we found that staff did not always keep a reliable record of care and treatment given to patients in the department. We reviewed 10 adult care records for patients waiting in ED. We found incomplete risk assessments for 3 patients in ED for over 5 hours. Two of the 3 patients were identified as high risk of pressure ulcers upon presentation to ED, they did not have entries relating to pressure care or comfort rounds for the 5 and 10 hours they had been ED. This was escalated to the practice development nurse (PDN) immediately. Following the inspection senior leaders reviewed the notes and reported no harm had come to either patient. Staff involved were given feedback on the importance of maintaining timely records of patients' care and treatment.

Is the service effective?

Inspected but not rated

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. However, pain relief was not always offered in a timely way.

Staff asked and recorded patients pain scores on the electronic record system during routine observations. We observed this completed upon review of review of 6 patient records.

Patients did not receive pain relief soon after it was identified they needed it or they requested it. The trust did not have in place patient group directives (PGD) for administering pain relief in the emergency department. PGD's allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. Due to a lack of PGD's nurses were unable to quickly provide pain relief and had to wait for doctors to

prescribe for each individual patient. This meant that patients did not always receive pain relief soon after it was identified in line with individual needs and best practice. During inspection a patient reported waiting for over 7 hours before being prescribed pain relief. A review of the notes confirmed that a prescription chart was not completed until 9 hours after arrival when a doctor completed a medical review.

Senior leaders reported that any delays in venous thromboembolism (VTE) prescriptions were classified as an incident. They were working a pharmacist to define roles and responsibilities and were in the process of collecting data to review the current VTE provision within ED. The trust had not developed a policy regarding the prescribing of VTE in ED, we were not assured that patients identified as high risk of VTE received pharmacological intervention as soon as possible. This was not in line with national institute for health and care excellence (NICE) guidelines people aged 16 and over who are in hospital and assessed as needing pharmacological VTE prophylaxis start it as soon as possible and within 14 hours of hospital admission.

Following inspection senior leaders had approved 16 PGDs for use across the Emergency Department. There was a clear plan in place to train senior nurses to be competent in the use of PGD's for patients in ED.

Competent staff

The service made sure staff were competent for their roles.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A Practice Development Nurse (PDN) had been appointed since July 2022 for ED. The PDN had oversight of education programmes and professional development of registered and unregistered nursing staff within ED. There was a learning and development plan for each nursing band. The PDN demonstrated a understanding of the policies and procedures for inducting all staff and had developed a structured induction program for new international recruits. New recruits rotated throughout the ED over a 4 to 6 week period working at a lower grade until they received their pin and successfully completed their induction. Induction training for all staff was developed in accordance with Royal College of Nursing (RCN) national curriculum and competency framework for emergency nursing.

Managers made sure staff received any specialist training for their role. A paediatric PDN carried out quarterly training on a range of subjects to ensure staff maintained their skills and practice based on current evidence for all staff. A review of records showed a wide range of learning and development opportunities to maintain knowledge and skills to treat children presenting to the department.
We were told that attendance for all nurse training was recorded electronically. However, the trust did not provide this data when requested.

Medical training sessions were run monthly at a regular meeting time that enabled attendance for junior doctors. There was evidence of comprehensive training programmes set up for both medical and nursing staff. The trust did not record medical attendees for these sessions, therefore managers could not evidence the compliance of attendance there was no oversight on who had attended training. We were told senior leaders were to record all attendance to sessions from May 2023, in addition to the date and title of the training session.

Following inspection, the trust reported the training for PGDs would be carried out by advance care practitioners to ensure all triage staff were competent within ED. We saw that this was placed on the risk register with mitigating actions being monitored.

Urgent and emergency services

All staff undertook specific training for their job role with a clear plan. Senior specialists worked closely with the PDN to teach and assess skills against set standards developed by the trust. Medical staff held monthly clinical governance meetings and identified learning from incidents which were shared with staff and identified further training needs.

Managers met monthly to identify areas of improvement and learning within ED. Staff had protected time to completed training to ensure they had competencies signed off. Compliance against completion of mandatory training was reviewed by senior staff at speciality meetings with action plans to support staff to complete identified training. We observed this was recorded in minutes dated 22 February 2023.

A medical staff member reported they were encouraged to complete and attend training but said it could be difficult to balance service provision over personal development.

During our inspection we found that both nurses working within resus had received immediate life support training. This is in line with Health Education England guidance 'Care skills Training frame (England) Statutory/Mandatory Subject Guide'.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with an agency nurse during our inspection, they reported they had completed an induction training program and felt staffing levels had improved more recently.

A junior staff nurse reported having training in safeguarding and they knew when and how to refer to the safeguarding team. They felt that managers were approachable, friendly and supported staff in difficult situations.

Nine new international recruits were enrolled onto a 6 week structured induction program to cover all mandatory training. The induction program also involved working short and long days as supernumerary initially to gain experience and confidence. Once competencies and training were completed these new staff would be rostered to work as part of the planned numbers in ED.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. 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. The trust had funded 2 children's and young persons (CYP) mental health liaison nurse posts since November 2022. There was a vacancy in 1 post which was being recruited to at the time of inspection. The nurses reported the role was about driving change and improvement for children attending the department with mental health illness.

Urgent and emergency services

Rapid access cards had been implanted within children's ED whereby a patient could present the card which would explain they had a mental health concern. This meant that they did not have to explain their symptoms which can be intimidating and were easily signposted to access the support they required in a timely manner. On inspection we saw large posters in the department explaining the cards and the specialist nurse was looking to implement this system in the adult ED areas as well as distributing the digital phone version to local schools.

The trust charities team had provided funds for care boxes for children with items such as colouring, games and toys.

New care plan paperwork had been created with more details of psychologists and social workers as well as alerts for autism, learning disability to ensure that referrals were made promptly. There was a plan to set up an intranet page to assist staff in accessing services to support patients.

During inspection we observed a patient with learning difficulties in the department who was distressed. Staff were supported by the learning disabilities nurse specialist. This patient was expedited to a more appropriate area quickly which meant that the patient was cared for by staff that understood their individual needs and staff responded in a prompt and appropriate manner.

At the time of inspection 2 adult mental health patients were in ED after 40 hours, they were cared for by the registered mental health nurse in the department. The trust had discussed these patients with the integrated care board to find the most suitable place to transfer for their ongoing care and treatment.

A dementia patient who wanted to walk around the department was supported by a health care assistant. We observed kindness and compassion in keeping them safe and calm in a busy environment.

Access and flow

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

Patients accessed the service by self-presentation at reception or via ambulance.
The current national standard is 95% of patients attending the ED should be seen and treated, admitted or discharged within 4 hours of arrival.

The daily situation report (sitrep) is data that all trusts with a type 1 A&E must complete. It indicates where there are pressures on the NHS around the country in areas such as breaches of the 4 hour waiting time, ambulance handover delays and bed availability. The NHS England SitRep data showed the national average for patients spending less than 4 hours in major A&E is 49.6%. The trust performance was reported as 65.7% of patients waiting over 4 hours in December 2021 and 50.9% in December 2022. This shows an improvement in the trust performance since our previous inspection when performance for patients waiting over 4 hours was consistently over 70%. However, the trust was still performing consistently below the national average.

Time to treatment had not improved since November 2021. January 2023 NHS digital A&E quality data showed time to treatment was 103 minutes in November 2021 and 101 minutes in November 2022. Wait time from arrival to review by a doctor or nurse was 6.2 and 6.5 hours respectively.

Urgent and emergency services

The trust reviewed their performance against the 4 hour standard at monthly speciality meetings. From January 2023 to March 2023 there has been a steady improvement from 50% to 70%. Leaders acknowledged that there needed to be a more robust process in place to achieve the 95% standard. The trust had addressed this through the 'In' and 'Out' transformation project which looked at the limiting factors around flow throughout the hospital and ways to address these.

The average time spent in the department for non-admitted patients was 4.7 hours and the average time for the admitted pathway was 15 hours. This data had not improved and was worse than our previous inspection in 2021. The trust was looking at flow from ED to the acute assessment unit (AAU), timeliness of speciality reviews and had planned to ensure the correct provision of portering was available to allow facilitate the flow to address delays for patients waiting for beds in the department.

The national average percentage for ambulances waiting at hospital for more than 60 minutes n September 2022 was 26%. The trust performance against this at our last inspection was 26.7% in August 2021. This data had not improved and increased to 51.8% in August 2022. This meant patients on average were almost waiting double the time on an ambulance compared to the year before.

The trust set an internal professional standard of 31 to 60 minutes for speciality review. Data showed they consistently did not meet this standard. An audit carried out by the trust on 5 March 2023 showed a compliance of 25% within this timeframe and 18% of patients were seen between 61 to 90 minutes.

The trust were working with an external company to develop a dashboard to enable review of data in real time against set standards and a better oversight of trust performance.

A lack of flow throughout the department meant that patients were not always seen promptly or within the appropriate area. Patients arriving by ambulance were assessed within the RAT area. During our inspection patients took 15-20 minutes on average to triage, exceeding trust policy. The trust recognised the rapid assessment treatment (RAT) process was not sufficient to meet the demand on the service . To address the delays in RAT, the further assessment unit was being trialled for 6 months to help support the service achieve the 15 minute triage trust target and strengthen the RAT process in line with trust policy. The further assessment unit was developed to improve patient safety, experience, improve performance against local and national standards as well as contribute to the reduction in ambulance handover delays. Clear exclusion criteria were displayed within the unit.

During inspection the hospital had received a pre-alert for a patient due to their deteriorating condition. They had a NEWS score of 8 indicating the need for admission directly to resus, however there was no space within resus on arrival. We observed staff assess and treat the patient on the ambulance and moved to majors 2 whilst awaiting space in resus to mitigate risk.

A review of the further assessment unit data showed a reduction in length of stay for non-admitted patients by 40%. It reduced from an average of 10 hours to 6.5 hours. Data also showed an increase of medication given. This meant patients were receiving medication much earlier on in their pathway. Senior leaders reported a further extension of the trial to drive improvement around 4 hour standard with clear key focus points.

Following inspection, senior leaders told us they were also working closely with the hospital ambulance liaison officer (HALO) to develop systems to identify patients that were fit to sit and review escalation processes in order to optimise flow through the department and meet RAT assessment targets.

Urgent and emergency services

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced but did not always provide effective mitigation to risks when these were escalated to them. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The trust had an established triumvirate structure which included a divisional director, associate director of nursing and associate director of operations. The urgent and emergency department had been restructured since our last inspection as a healthcare group to increase clinical leadership and strengthen triumvirate working.

The urgent and emergency care department was led by a Clinical Director, General Manger and a newly appointed Matron who was due to start in post in May 2023.

Staff described a working area that was highly pressured with increased patient attendance. Senior leaders were committed to increasing their visibility and wanted to created opportunities for staff to feedback on the ED service they worked in. Staff we spoke with on the day of inspection reported they felt comfortable to raise concerns or service improvement ideas.

Senior leaders and operational managers were visible during the inspection, however, there were times where we had to raised concerns around staffing numbers to meet the demand on the service. We observed a request for support from a member of staff due to high demand on the service, and additional support was not provided in a timely manner. We were not assured that leaders were always responsive to the staffing demands of the service.

Leaders had been responsive and addressed many of the concerns we identified on our previous inspection including improving mental health support for patients, implementing a nationally recognised triage tool and improving 4 hour wait times. However, leaders did not always identify areas that needed further improvement such as ensuring risk assessments and patient observations were completed in line with policy, y and that patients were triaged or streamed within national guidelines.

The triumvirate were aware of the pressures the service faced regarding performance against national professional standards impacting on flow and overcrowding within ED. The trust were trialling new ways of working such as a new medical staffing model and the further assessment unit in place to address these but the effectiveness against trust targets and national standards were yet to be ascertained. Ongoing staffing vacancies and compliance with training was reviewed monthly. A review of the ED speciality meetings dated 12 January and 9 March 2023 showed planned and completed actions such as overseas recruitment, use of agency assisted recruitment and a completed project to implement monitoring of booked and completed training for staff so that it could be monitored directly with compliance for the last month minuted.

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.

The trust launched their quality and patient safety strategy in November 2021. The service had a local strategy which reflected the trust's overarching strategy and had targets and goals. The triumvirate had oversight on the key deliverables needed to ensure successful delivery of the strategy. Senior leaders confirmed that a strategic committee was in place. The strategy was focused on sustainability and working in partnership with the wider system through integrated care partnerships and system wide planning.

The trust worked in line with their strategic objectives. For example, work had been completed with partners in the integrated care system to improve pathways of care for patients. During the 11am huddle we observed discussions between the trust and community partners to place a mental health crisis patient in appropriate setting as they had been waiting in the ED over 2 days.

Senior leaders told us that they communicated with staff in a number of ways to ensure the strategy was a shared goal. These included the use of notice boards, emails and a weekly ED staff newsletter. Staff were encouraged to offer alternative methods of communication of information to improve delivery. The newly appointed supernumerary nurse was tasked with delivering 3 key messages a week to staff in order to improve knowledge around the shared strategy within ED.

The trust was working with NHS England Improvement Capability Building and Delivery (ICBD) team to support them in achieving their strategy by engaging with staff and ensuring they were equally invested in the sustainability of the services provided.

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 were continuing to work towards an open culture where patients, their families and staff could raise concerns without fear.

We spoke to a total of 25 members, both nurses and doctors of various positions. All staff on the day of inspection stated that they felt supported in their role. Managers praised their staff and stated they were proud of the team and the commitment they showed to improving care and standards within the department.

Following a trust wide reorganisation in 2021, the urgent and emergency care division was formed. Senior leaders within this division had committed to working with teams to ensure a culture where staff felt able to share their experiences of working in ED.

NHS staff survey completion for ED rose from a completion rate of 31.7% to 43.6% from 2021 to 2022, with a target response rate of 50%. In paediatric ED response rate improved from 31% to 32.4%. In order to further improve staff engagement and staff survey response rates senior leaders had committed to a programme of feedback to action, where they will work collaboratively with teams to address the feedback.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Senior leaders worked hard to ensure the culture encouraged openness and honesty at all levels of the organisation. There were systems in place such as a 'Speaking Up' policy, disciplinary policy and Freedom To Speak Up Guardians (FTSUG) including a named Non-Executive Director who championed Freedom To Speak Up.

"Here to hear" listening events were held in January 2023 for all paediatric staff across ED and wards to share views, experiences and feedback about working in their team. Senior leaders were not present during these events. The staff were facilitated by organisational development and human resources business partnering teams, creating a confidential space for these discussions. The trust took action and responded to themes raised. Senior leaders developed a redeployment standard operating procedure and undertook a safe staffing review using the safer nursing care tool in response to staff feedback at these listening events. Mangers had agreed the recommendations and made changes to the establishment of staffing.

An anonymous staff survey was carried out by leaders to gain a deeper understanding of how staff felt working in the division and the care they were able to provide patients. The data would be analysed by NHS England ICBD team with hopes of facilitating a workshop around the barriers to providing the best care for patients. The outcomes and actions from this event are yet to be evaluated and demonstrated against trust targets.

Senior leaders told us there was a strong emphasis on the safety and well-being of staff and there were a number of processes in place to support staff. This included mental health first aiders and occupational health services.

Governance

Leaders did not always operate effective governance processes throughout the service.

The governance had been strengthened since our last inspection however systems were not always effective to assess, monitor and improve the quality and safety of services.

The service had processes in place to assess and escalate staffing concerns however on the day of our inspection we found that these processes were not always effective. We had to escalate our concerns around the lack of staff triaging patients at the front door and the impact on triage times twice on the day of our inspection. A staff member had escalated when they were the only nurse in resus with 4 patients to attend to when their colleague was on a break. We saw that no action was taken by the leadership team to mitigate this risk.

The service submitted data on risk assessments and patient observations as part of their Section 31 Conditions under the Health and Social Care Act 2008. From this data we saw an improving picture on compliance with completing risk assessments and patient observations. On inspection we found that whilst the services initial streaming risk assessments and patient observations were consistently completed, full risk assessments and care plans and follow up observations were not always consistently completed in line with policy. The services data did not reflect a full and accurate picture of the services performance.

Staff from ED would feed back concerns, risks and issues into local team and department meetings which fed into the triumvirate to the senior management team that reported to the trust board. Risks and concerns relating to ED were presented to the trust board and actions were communicated to staff via department meetings. Monthly patient safety and quality (PS&Q) governance meetings with the lead PS&Q facilitator for the trust reviewed the key issues from the subcommittee meetings and escalated matters for the board.

Urgent and emergency services

We reviewed a variety of monthly meeting records such as a monthly speciality meeting and performance review meeting minutes dated January, February and March 2023. These minutes showed that staff discussed quality and performance to identify any emerging risks, they also reviewed existing risks across the service. Areas covered included staffing skill mix and levels, harm free care, falls risks, incidents, pressure ulcer prevalence, shared learning and other key information.

The joint collaborative children's and ED meeting reviewed incidents and risk registers across both divisions delivering care in ED. They discussed shared learning and looked at the effectiveness of the department against national and local standards set. However, we reviewed the last 3 meeting minutes from March and April 2023 and found that it had been recently reinstated having been stopped/removed from calendars. Following inspection, the meeting documentation of the meeting changed from an action log format to formal minutes.

The trust had standard operating procedure in place for streaming children presenting to ED, but there was no equivalent document to support the decision making for the adult pathway. Staff told us there was a lack of clarity around ownership and responsibility of patients presenting to the ED by ambulance. Staff were unclear whether patients were the responsibility of the ambulance service or the ED during ambulance streaming.

In response to our inspection the service drafted a draft patient flow escalation policy. This policy set out roles and responsibilities of staff in managing patent flow and support safe and effective escalation. Internal professional standards with target time frames.
Management of risk, issues and performance
Leaders and teams used systems to manage performance. They did not always identify risks and issues to reduce their impact.

There was insufficient oversight of staffing in all areas of the department during inspection. This was identified at the last inspection and although staffing has improved compared to the previous inspection, we were not assured that the systems in place were responsive to the needs of the patients over a 24 hour period. Safety huddles at 8am, 11am, 1pm and 8pm allowed leaders to redeploy staff in response to pressures in the department. However, during inspection we had to escalate staffing concerns on 2 occasions and 1 occasion observed staff escalation that was not supported. Although systems were in place, we were not assured that they were effective enough to manage the performance in a responsive manner. Since the inspection, managers told us they have set more formal processes to encourage staff to escalate to ensure patients received the right care promptly and reduce lengthy wait times.

Leaders had recently appointed a matron and supernumerary nurse within ED, however, they were not due to start until after our inspection. Leaders were hopeful they would provide further oversight of the department to manage performance.

Leaders used the safer staffing tool to plan nursing rosters and used the Management and Escalation of Nursing & Midwifery Safe Staffing Levels policy when staffing had not met the planned numbers. Staff had not been redeployed to meet the demand on the service and the impact of amber staffing was evident in the delays in rapid assessment and treatment (RAT) time, long ambulance handover delays and time to triage in excess of 60 minutes on 2 occasions during our inspection.

The service's risk register was discussed at monthly quality and safety meetings. All risks we identified on inspection were documented on the services risk register including staffing, risk assessments and performance around triage times.

Urgent and emergency services

The service had mitigating actions in place and discussed these at the meetings. However, we were not assured these mitigating actions were effective as low nurse staffing and a lack of effective escalation had led to significant triage delays on the day of our inspection. Furthermore, risk assessments and patient observations were not completed in line with the service's policy despite these risks being on the risk register.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. We saw noticeboards in prominent places with information on incidents and learning this included the "This is me" staff briefing newsletter.

The service had processes in place to monitor performance and we saw that performance had generally improved since our previous inspection but remained below the national average for most data sets including ambulance turnaround performance and A&E waiting times.

The service had a local emergency resilience preparedness plan which helped to ensure the A&E was prepared for unforeseen service interruption.

Outstanding practice

We found the following outstanding practice:

- The emergency department had improved its service provision for mental health crisis patients. The trust had ensured a registered mental health nurse was rostered on every shift to meet the needs of these patients and ensure that risk assessments were completed in a timely manner.

Areas for improvement

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

MUSTS

- The trust must ensure there are effective escalation procedures in place in the event of staff shortages. (Regulation 17)
- The trust must ensure full risk assessment and care plans are completed in line with policy for patients assessed to be at risk during triage. (Regulation 12 (2)(a))
- The trust must ensure that patients receive ongoing observations in line with policy (Regulation 12(2)(a)).

SHOULDS

- The trust should consider streaming patients effectively to reduce the demand on the service (Regulation 17)
- The trust should ensure their medical staffing meets the demand of patients overnight to avoid lengthy delays (Regulation 18)

Urgent and emergency services

- The trust should ensure call bells are within easy reach for patients. (Regulation 12 (2)(e))

Our inspection team

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