Guy's and St Thomas' NHS Foundation Trust

St Thomas' Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at St Thomas' Hospital

Inspected but not rated

We have not changed the rating of this key question, as we have only looked at the part of the key questions that we had specific concerns about including the winter resilience questions. The purpose of this inspection was to check a specific concern we had about care and treatment for mental health patients, staffing, medicines and environment. We will assess all the key question at the next comprehensive inspection of the service.

The emergency department based at St Thomas' Hospital provides consultant-led emergency care and treatment 24 hours a day, seven days a week to people across the London boroughs of Lambeth, Southwark and Westminster as well as people out of area.

We inspected the service using the winter resilience methodology. We did not inspect any other services as this was a focused inspection in relation to urgent and emergency care.

We carried out this unannounced focused inspection because we had concerns about the quality of services for mental health patients. We did not enter any areas designated as high risk due to COVID-19. The inspection framework focused on five key lines of enquiry relating to critical care, infection prevention and control, patient flow, workforce and leadership and culture.

During the onsite visit to the emergency department we became aware of concerns about the care of a mental health patient who had been in the department for three days due to lack of beds in an acute mental health setting for the patient to be transferred to. The issue was escalated to the NHSE&I and the clinical commissioning group (CCG).

We did an unannounced focused inspection of safe, responsive and well-led domain. We only looked at those areas in our standard plan for assessing pressure on emergency departments.

We did not rate this service at this inspection. The previous rating of outstanding remains.

We found:

- The service had staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risks well.
- Staff assessed risks to patients, acted on them and kept accurate care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- 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.
- 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 these in their work. Staff were clear about their roles and accountabilities.
- We observed improvements in the physical environment where patients were rapidly assessed and treated. This was now consultant led with consultant cover for 16 hours out of every 24 hours.

Our findings

- There were clear clinical care pathways and protocols in place, with pre-agreed parameters for patients being seen in designated areas.
- Patients received timely clinical input and assessment. We observed patients' risk assessments were appropriately completed and that patients were reviewed based on their clinical needs.
- Staff were aware of, and used, the trust's escalation processes in order to manage flow and reduce risks of crowding within the department.
- Staff understood how to manage infection prevention and control and all areas were visibly clean. Staff wore appropriate personal protective equipment (PPE) to keep themselves and others safe from cross infection.
- There were systems in place for infection prevention and control. All staff and patients adhered to personal protective equipment (PPE) guidelines. There were clear isolation and separation areas to manage the care for patients due to COVID-19.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and easily available to all staff providing care. Patient records were managed securely.

However:

- The service did not have enough medical registrars to meet the recommended guidance for the department or be able to develop the service. There were insufficient numbers of medical registrars in post.
- The service did not always have enough substantive clinical staff to care for patients and keep them safe without using high numbers of temporary bank, locum and agency staff.
- Staff told us that at periods of high demand and increased capacity sometimes there could be a delay in adjusting and managing the ratio of nurse patient ratio.
- The service should ensure that records relating to decisions to administer rapid tranquilisation clearly identify the clinician who made the decision and details of the reason for administering the medication.
- The service should continue to participate in multiagency partnership arrangements for managing people experiencing mental health crises.
- People could access the service when they needed it and received the right care. However, this was not always promptly as waiting times from patient arrival to treatment and arrangements to admit, treat and discharge for mental patients were not in line with national standards.
- Although leaders and teams identified and escalated relevant risks and identified actions to reduce their impact, they were not always able to prevent reoccurrence. The service was not always managing issues early enough to prevent them from becoming problems.

How we carried out the inspection

We spoke with 12 staff including: the clinical lead, a consultant nurse, a practice development (PD) nurse, the head of urgent and emergency care, an emergency department matron, emergency department (ED) consultants and nurses.

The inspection was carried out over two days by a CQC lead inspector, supported by two CQC mental health inspectors and a consultant doctor as a specialist advisor with experience of emergency department care.

Our findings

We carried out the unannounced part of the inspection from midday on a Monday 21 June 2021 from 12 noon till 9pm as this is usually a busy period for hospital emergency departments.

We reviewed 15 patient care records and we analysed information about the service provided by the trust following our inspection.

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

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

We have not changed the rating of this key question, as we have only looked at the part of the key questions that we had specific concerns about including the winter resilience questions.

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Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The staff received mental health training within the department as part of their study days and recently attended training provided by the psychiatric liaison team. Senior nurses had attended training on reducing restraint and improving safe practice. Security staff completed mandatory training in the Mental Health Act 1983, working with vulnerable adults and working with adults with dementia. Staff within the enhanced care team completed basic training on mental health conditions. The enhanced care team are the team of mental health staff (mental health nurses and support workers) who provide mental health care and treatment to patients receiving care at the hospital. However, staff gave mixed views on their experience of the training provided. Some security staff said they had no specific training in mental health, learning disabilities or autism. Nursing staff said they would benefit from more specific training in autism.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. The trust provided adult safeguarding (level two) training. All staff were required to complete this training every three years. All staff had completed this training in 2019 as part of the departments safeguarding themed development days. Staff told us they received regular training updates in adult safeguarding and child protection and training was delivered to all new staff at their induction as a mandatory subject.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, during initial assessments nurses asked patients if they had any children and how they were being looked after. If patients refused to answer these questions, nurses escalated the matter to the nurse in charge. Staff checked information from previous admissions and contacted other agencies, such as the patient's local authority, to find out more information when necessary.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Records showed that comprehensive safeguarding referrals were made to the relevant organisations in a timely manner.

Urgent and emergency services

Safeguarding policies and pathways were in-date and were accessible to staff via the trust's intranet. These included clear guidance on completing the multiagency referral form. Staff had access to the trust safeguarding lead for advice. There was specific guidance for caring for patients who presented with non-accidental injuries for children and adults.

Staff knew who they should inform either in the department or within the trust with concerns.

The enhanced care team supported patients presenting with mental health needs. This is a 24-hour service across the hospital. The service had a team leader (Band 7), six senior nurses (Band 6), 11 nurses (Band 5) and 37 healthcare assistants (Band 3). There were two vacancies for healthcare assistants and seven vacancies for band 5 nurses at the time of our inspection.

Mental health patients were triaged by a registered general nurse (RGN). If the triage identified the need for additional support, the RGN bleeped the enhanced care co-ordinator. A member of staff from the enhanced care team provided support to the patient whilst waiting for an assessment by a registered mental health nurse (RMN) from the psychiatric liaison team. Referrals to psychiatric liaison and enhanced care were made at the same time.

There is a specific pathway for patients who present as being intoxicated. Risk assessments were carried out at the triage and assessment stages of the process. If a patient is distressed, they could wait in one of two cubicles in majors that were designated for mental health patients.

Cleanliness, infection control and hygiene

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

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand washing facilities, alcohol gel and hand conditioner were readily available throughout the ED. The trust had dedicated areas for staff to put on and remove PPE and clear signage was in place to remind staff, patients and visitors of the importance of infection control.

Staff followed, 'Bare below the Elbow' guidance, and wore PPE such as gloves and aprons whilst delivering care, in line with trust policy. We observed most staff following correct use of PPE and required hand washing. Staff disposed of PPE in clinical waste bags. Staff told us they had no problems with accessing the PPE required to do their work safely and reduce the risk of infection.

Handwashing facilities and decontamination gels were readily available for staff and visitors to use. There were visible instructions at ward entrances which informed visitors to the ward of the importance and methods of hand cleansing and use of PPE. All staff we saw were bare below the elbow and decontaminated their hands between patient contacts.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff routinely cleaned equipment, and patient trolleys, after every patient contact and labelled equipment to show when it was last cleaned. We observed staff using "I am Clean" stickers throughout the emergency department (ED) to show when equipment had been cleaned and was ready to use. During the inspection we saw housekeeping staff cleaning all areas of the department. The contractor displayed results of their consolidated audit scorecard on a notice board which confirmed for the period **21 April to 24 April 2019** they passed with a score of 97%. This meant staff and patients were assured the department had been cleaned.

Urgent and emergency services

Clear signage reminded staff, patients and any relatives of restricted access to high risk areas. There were clear isolation and separation areas to manage the care for patients due to COVID-19. Patients were grouped together as per the results of their COVID -19 test status.

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.

There were two cubicles in major treatment area that were designated for patients receiving a mental health assessment. These cubicles were clean and suitable, equipped with seating of up to four people. There were no apparent ligature points.

There were two rooms in the multi-specialism assessment unit designated for patients presenting with mental illness. Both these rooms were in use during our visit and we were unable to go into the rooms. A psychiatric liaison team member said the rooms met the appropriate standards, including having observation panels, call buttons, good lighting, two doors, one door opening outwards, and anti-ligature ensuite facilities.

Spaces was limited in the department. At times, doorways were temporarily blocked due to patients queuing up to register, which caused the main door to be blocked. The physical size of the corridors restricted the ability for department staff, ambulance crews and patients to socially distance to two meters. During periods of high demand, it was not easy for ambulance staff to handover patients on trolleys and maintain patient confidentiality, as people passing through the corridor could be overhead during the handover.

The service had enough suitable equipment to help them to safely care for patients. The service had suitable facilities to meet the needs of patients' families. Staff carried out daily safety checks of specialist equipment, and mostly disposed of clinical waste safely.

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 knew about and dealt with any specific risk issues. For example, staff completed the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) to measure the effects of alcohol withdrawal on a patient. This helped to inform the level of medication and ensure the risks of alcohol withdrawal were managed safely.

The service had 24-hour access to psychiatric liaison team and specialist mental health support. The psychiatric liaison team provided by the local NHS mental health trust was based in the emergency department and provided a 24-hour service. The emergency department referred, on average, 13 to 14 patients to the psychiatric liaison team each day. The service provided registered mental health nurses, a core trainee doctor and mental health consultants. The service also employed administrators who made arrangements for patients to be discharged to mental health services in their local area. Clinical staff sought advice from psychiatric liaison team about what to do if the patient attempts to discharge themselves or refuses treatment.

Staff completed or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff completed a detailed risk assessment of patients using a standard assessment tool. This tool

enabled staff to classify the risks as low, moderate, high or severe depending on the patient's presentation. Patients classified as presenting a high or severe level of risk were allocated a member of staff to carry out enhanced one-to-one observations. Nurses also referred these patients to the psychiatric liaison team for a comprehensive mental health assessment.

Nursing staff told us acuity and complexity have become more challenging since the pandemic and the service was seeing more patients. Staff told us that there had been an increase patients attending who had self-harmed and / or attempted suicide. The number of patients admitted for psychiatric reasons had increased in the last year. Between 1 April 2020 to May 2021 there were 3121 mental health patients seen at the department. Delays in getting access to onwards care beds had meant the highest risk patients stayed in the department for longer.

When people arrived at the department, they were triaged into appropriate specialty. There were two cubicles in majors designated for mental health patients. These cubicles were used for mental health assessment and information gathering with the mental health liaison team. These were provided by the trust and is staffed by mental health professional 24 hours a day. If a patient was distressed the staff attempted de-escalation. Physical interventions were agreed by the most senior doctor in discussion with the psychiatric nurse practitioner.

Restraint of an acute mental health patient was carried out by security staff. They were trained to do so. They recorded any incident of laying hands on a patient on the electronic incident system. All incidents involving mental health patients were reviewed every two weeks in meeting with the trust and the nearby mental health trust.

There were arrangements to manage other patient risks such as those related to the taking of unprescribed medicines or overdosing.

Delays in the discharge of mental health patients to ongoing care were common, there were 35 delayed discharged in the department between January – June 2021.

On the first day of our inspection, we found there was a patient who had been waiting for a bed at the psychiatric intensive care unit (PICU) for three days, as there was no capacity in PICU. A psychiatric intensive care unit is a hospital ward dedicated to the short-term management of people in an acutely disturbed phase of a serious mental disorder who cannot be safely managed in a general psychiatric ward. Core features include a high staff to patient ratio and a secure physical environment.

Staff told us it was very easy to get an assessment under the Mental Health Act (MHA) and that the local authority was usually very responsive, although there had been some gaps in the section 12 (s.12) doctor rota the day before the onsite inspection. Section 12 doctors were those that were registered under the MHA to undertake emergency mental health assessment in ED.

Nurse staffing

The service had enough nursing staff 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 staffing levels and skill mix, and gave bank and agency staff a full induction.

There was a named nurse in charge on each shift. Staff knew where this nurse was in the department and on the day of our inspection, this nurse was observed to have a good oversight of the ED.

Urgent and emergency services

Staff told us that unfilled shifts were escalated to senior leaders, who filled these shifts with bank, agency staff or staff from other areas of the hospital. Staffing were planned to meet hourly, daily and seasonal variations of demand. There was regular review of patient acuity which meant that more staff could be requested in times of increased capacity and surge to promote patient safety. Due to COVID-19 related sickness, bank, and agency staff (temporary staff) were being used in the ED. We saw most of the sickness was covered by bank staff. When agency staff were used these staff were familiar with the ED and were block booked where possible to ensure consistency for the service.

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. During our inspection the number of nurses and healthcare assistants did not matched the planned numbers, however, this was mitigated by having other ED nurse managers on the floor to provide care and support, for example, we saw practice development nurse on the floor providing care.

Medical staffing

The service had 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.

Consultant cover was provided seven days a week from a roster of 8am to midnight. The overnight hours were covered by a registrar middle grade and junior doctors. There was a consultant on call for the hours where they were not physically present within the department. There was a range of differently skilled and experienced middle grade, junior doctors and trainees available. There was a senior in charge doctor for the night shifts from 12 midnight to 08.00. The ED clinical lead told us the department clear on the staffing levels required for safe staffing and is this supported by the trust senior leadership team.

We observed a safe, effective and thorough medical handover where issues regarding patient care, management and treatment were covered and senior staff reviewed patients after the handover as required.

Managers could access locums when they needed additional medical staff and they made sure locums had a full induction to the service before they started work. Medical staff told us they were appropriately supported with the training and induction needs.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The department had an electronic medicines management system. Medicines were stored in a designated room. A computer terminal was available to provide information on doses of medicines. All medicines were stored in a large, locked cabinet and there was a reliable system to manage medicines going in and out of storage facilities and to safely monitor the medicines room. The pharmacist for the emergency department received weekly reports on the dispensing of drugs liable for misuse. The service completed quarterly audits of compliance with the policy for controlled drugs.

The hospital's pharmacy team undertook stock top-up checks. We reviewed a random sample of medicines and found these were all in date. The controlled medicines register was completed appropriately.

Decision making processes were used to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Decisions to use medicines to sedate patients were made by a multidisciplinary team including nurses from the emergency department, nurses from the psychiatric liaison team, security staff and senior doctors. Medicines

used for sedating patients were in the range of recommended doses. Staff administered medicines for rapid tranquilisation in the resuscitation area of the department to ensure that observations of the patients could be carried out in accordance with national guidance. However, on some records, it was difficult to understand who made the decision to administer rapid tranquilisation. For example, on one record there was no entry by the senior doctor who authorised rapid tranquilisation, and whilst there were inferences about the reasons for the sedating patient, the decision making was not explicitly recorded. On another record, the patient received rapid tranquilisation on more than one occasion. The decisions to administer medicines on some of these occasions were not clearly recorded.

An external review of restrictive practice was carried out in 2020 which recommended an increase in restricted practice awareness and refresher course for staff. The service had trained approximately 50 staff to date after they had increased their restricted practice education for staff and introduced the two-day course. This training is an on-going training program.

Most medicines records that we saw, showed that medicines were given in a timely manner and charts properly completed.

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.

Patient notes were detailed, and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Clinical staff have access to patient-specific information, such as care programme approach (CPA) care plans, positive behaviour support plans, health passports and communication aids.

Records were stored securely. We reviewed 16 sets of patient notes. All nursing and medical records we reviewed, were of good quality. They were clearly written and had timely reviews of patients. Each set contained the national emergency department safety checklist, which was a tool required to be completed hourly. This covered completion of observations, nutrition and hydration and whether a patient had received food and drink in the department.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff recorded all incidents, including incidents of restraint, disturbed behaviour and rapid tranquilisation. Between 1 January 2021 and 26 June 2021, there were 38 incidents of restraint and three incidents of rapid tranquilisation. Staff recorded incidents on an electronic incident reporting system. Senior staff reviewed the details all reported incidents. However, the quality of consistency of entries on the incident record varied. Some records included clear details of the circumstances surrounding the incident, a description of what happened and details of how the matter was resolved. Other records only included very brief information. Staff at all levels understood the duty of candour regulation and were able to describe what the duty of candour involved, the actions required and where to look for guidance on the hospital's intranet if needed.

Urgent and emergency services

Managers debriefed and supported staff after any serious incident. One member of staff said they received very good support from colleagues after they had been involved in an incident. Another member of staff said there was always a short debrief after incidents to check everyone was ok, but sometimes it was difficult to have time for a more comprehensive review of what had happened.

Staff met to discuss feedback from incident investigations and look at improvements to patient care. Nurses from the emergency department and the psychiatric liaison team met with security staff each week to review any incidents that had taken place. Security staff reviewed images from body worn cameras. These images were uploaded to the incident report and discussed within the security team.

Is the service responsive?

Inspected but not rated

We have not changed the rating of this key question, as we have only looked at the part of the key questions that we had specific concerns about including the winter resilience questions.

Access and flow

People could access the service when they needed it and received the right care promptly.

The urgent and emergency care service was available 24-hours a day throughout the year. There were systems in place to manage the flow of patients through the ED and identify any patient waiting for an extended period to be seen.

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 the 12 months period between April 2020 to March 2021.

The service had an incident reporting system where organisational position including site status, risks and issues regarding flow were documented and managed. Staff could appropriately escalate any safety or flow issues to senior managers in line with the trust's capacity management and escalation policy.

National performance data for all types showed an average of 91% of patients were seen within four hours or less in ED between May 2020 and April 2021, which higher than average for England. It only went below 90% during two months within this time period.

The leadership team had an oversight and involvement in flow issues on a day to day basis through daily huddles. There were processes in place to monitor waiting times and managers and staff worked together to make sure patients did not stay longer than they needed to. Processes for monitoring waiting times were embedded in the day-to-day operational activities. Clinical staff discussed waiting times and delayed discharges during safety huddles and the nurse in charge escalated any concerns regarding patients who were approaching a breach in waiting or triage times to the ED leadership team.

Urgent and emergency services

Mental health patients could access the service when they needed it and were assessed promptly. However, there were often delays in transferring patients to other specialist mental health services when they required an inpatient admission. Waiting times from arrival in the department to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Managers and staff monitored waiting times to ensure that patients did not stay longer than they needed to due to lack of mental health beds.

Although staff treated patients with compassion and kindness, patients' privacy and dignity were not always maintained in the corridors during ambulance handover periods of high demand, particularly when history and vital signs was required to be taken. Privacy screens were not available for ambulance handovers.

The high demand for mental health patients. We saw ongoing assessment being taken on mental health patients. Staff were able to support the needs of patients attending with mental health symptoms through referral to the mental health liaison team who were located within the department.

Staff mostly supported and involved patients to understand their condition. We spoke with three patients and one relative. All three patients told us that staff had kept them updated on their condition, their care and progress towards when they would next be seen. The patients we spoke with were generally happy with the level of care they had received at that point of time. The service moved patients only when there was a clear medical reason or in their best interest. There were appropriate discharge arrangements in place for people with complex health and social care needs.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. For example, the service provided sunflower lanyards to people with learning disabilities so that staff could quickly recognise disabilities that may be unseen. Similarly, the service used blue wrist bands to identify patients with dementia. The enhanced care team provided additional support to these patients.

Staff had access to communication aids to help patients become partners in their care and treatment. The department had a box of communication tools to assist in engaging with patients. This included visual pain scales and cards with facial expressions to help patients communicate how they were feeling.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. This was provided by the psychiatric liaison service based within the department.

The psychiatric liaison service saw patients within one hour of the referral.

Is the service well-led?

Inspected but not rated

We have not changed the rating of this key question, as we have only looked at the part of the key questions that we had specific concerns about including the winter resilience questions.

Urgent and emergency services

Leadership

Leaders had the 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 department had a dedicated leadership team who were responsive to the needs of patients, developing staff and improving safety. Leaders we spoke with were aware of the day to day challenges staff faced during the pandemic and throughout the winter pressures and were keen to improve recruitment and the department to work better for staff and patients.

We were told the leadership team listened and there had been a number of improvements made to the department to reduce the risk and spread of COVID-19 to staff and patients such as specified areas for COVID-19 patients with negative pressure rooms in place.

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service.

There was effective and supportive management of the department by the emergency physician in charge and the nurse in charge. This was undertaken well and with regular reviews of each patient in their charge, to check on safety and progress.

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.

During the inspection we saw that all staff throughout the department worked well together and appeared to be a strong, cohesive and well-functioning team. Some of the nursing staff spoke positively about their managers and told us they felt supported by their managers. However, some staff also expressed their frustration for not always been able to give the quality of care they would aspire to mental health patients due to heavy demand. Despite this, we did not observe any significant lapses of care for mental health patients during our onsite inspection.

Senior staff told us nursing staff had worked exceptionally hard in very difficult circumstances, nursing staff in the department supported each other well, and there was supportive team working within the department.

Staff we spoke with described an open culture where learning from incidents was encouraged and staff were actively engaged in developments within the department. Staff spoke highly of the senior leadership team and described them as approachable, knowledgeable and supportive.

Learning and development in the department were supported by a dedicated practice development nurses working in the department. Staff felt valued, they felt that the leadership team had provided additional support during the pandemic and that a culture of working together had been a key focus to ensure patent and staff safety. During our inspection we observed mutually respectful interactions between staff and patients.

Governance

Leaders operated governance processes. 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.

Urgent and emergency services

Leaders and teams used systems to manage performance effectively. Managers we spoke with told us the trust's senior leadership team understood the challenges in relation to the quality and sustainability of effective patient care during the COVID-19 pandemic. The executive team had regular oversight of the trust's unplanned care improvement plan and actively supported and challenged progress.

The governance of mental health across the Trust, including the provision of mental health services within the emergency department, was overseen at the mental health board chaired by the director of nursing for vulnerable adults and supported by the mental health lead. The mental health lead had a strategic role pertaining to mental health care within the Trust and provides expert guidance to the directorate senior management team in relation to mental health related issues within their clinical areas. This includes working in conjunction with the clinical groups and the local and central quality & assurance teams, as well as SLAM partners to have an oversight of mental health related patient safety, effectiveness, practice and compliance with legislation.

The trust used a multidisciplinary approach to managing key challenges within the ED. This included the management of flow using combined operational and clinical meetings with divisional teams to address key issues, for example, staffing levels, escalation and risk.

The mental health board reports to the quality & performance committee, (this is a sub-board committee) of the trust board. This include sub-groups for Mental Health Act, representatives from the local mental health trust, local commissioners to the mental health board, operational group (join meetings with SLAM), support positive behaviour group, a children's mental health group and a mind and body group. The mental health board is chaired by the director of nursing for vulnerable adults with representatives from all directorates.

The mental health board met every two months. Recent discussions had been centered around COVID-19, suicide and new polices. The meetings also heard updates from all the sub-groups. Information from these meetings were cascaded to staff through local representatives.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The staff were able to demonstrate lessons they had learnt from the results of 2019/20 winter planning and had used these to improve the 2020/21 planning. ED and trust leaders had access to technology that enabled them to have consistent oversight of oversight of ED performance. Staff and leaders had access to real-time performance data for the ED. The electronic records system provided a live display of patient acuity, waiting times and specific performance areas such as waiting times, black breaches adult mental health and Child and Adolescent Mental Health Service (CAMHS) referrals. We saw senior staff and leaders monitor this data throughout our inspection.

Leaders had identified and escalated relevant risks and issues. They were working on actions to reduce the impact of risks and improve the outcome and experience for patients using the emergency department. They had plans to cope with unexpected events and were aware of issues and related to mental health and emotional wellbeing of patients when they at the department.

The service had a performance dashboard that focused on daily demands and capacity. This enabled managers to have access to the most up to date information and make decisions effectively in real time. The intelligence from the dashboard was discussed at their regular huddle meetings and reviewed with senior trust staff.

Urgent and emergency services

ED leaders told us how they attended regular leadership huddles. These huddles included leaders from other acute specialties within the trust with the aim of discussing and problem-solving operational issues, including issues with ED access and flow.

The department, alongside the practice development clinical facilitators, had put together a specific emergency department training module for all ED staff, and all staff were encouraged to attend.

The clinical governance meetings had a structured agenda of incidents, trends, complaints, audits, mortality, Coroner's inquest, infection prevention control and risk register. The department had a continuous clinical audit program in place.

Learning, continuous improvement and innovation

Staff were involved in initiatives to improve mental health care and treatment. For example, at the start of 2021, the emergency department introduced a new protocol for responding to mental health emergencies. This protocol facilitated a rapid response from staff in both the emergency department and psychiatric liaison service. The trust has also introduced a new training course on mental health which, at the time of the inspection, had been attended by 90 members of staff. Also, in 2021, the service commissioned a review of mental health practice in the emergency department which has led to the service updating its policy on rapid tranquilisation.

Areas for improvement

SHOULDS

- The trust should continue to work with the wider health and social care system and CCG's to improve flow from the ED to acute mental health services and specialty wards.
- The trust should review the numbers of senior medical staff on duty, particularly at night, so there are enough doctors to manage patients within the emergency department, where there may be the need to deal with urgent treatment especially for mental health patients.
- The service should develop a formal process for the clinical oversight of patients remaining in the department waiting for mental health beds.
- The service should continue to participate in multiagency partnership arrangements with key stakeholders (CCG's and Mental health services) for managing people experiencing mental health crises.
- The service should ensure that records relating to decisions to administer rapid tranquilisation clearly identify the clinician who made the decision and details of the reason for administering the medication.
- The service should ensure that assessments of patients' mental capacity are recorded and that this record includes the findings of the mental capacity assessment.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two CQC mental health inspectors and an ED specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.