Wye Valley NHS Trust

The County Hospital

Inspection report

County Hospital
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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at The County Hospital

Requires Improvement  

Urgent and emergency care was delivered by the emergency department (ED) based at County Hospital, Hereford. It provides consultant-led emergency care and treatment 24 hours a day, 7 days a week to people across Herefordshire and further.

The ED was split into different sections; 'resus', for patients who required immediate lifesaving treatment or resuscitation, 'majors', for patients with serious and life-threatening conditions; and 'minors', for patients who had minor injuries. There was a triage area or 'pitstop' where all patients were assessed and a 'fit to sit' area in majors for patients who were awaiting further tests or a bed in majors. There was a same-day emergency care unit which saw ambulatory patients who needed treatment or tests and could be discharged home after this.

There was a paediatric area used to treat children and young people, including a waiting area. There was a waiting room for patients who had made their own way to the department as well as a waiting area for patients waiting for treatment for minor injuries. In addition to these areas an internal corridor was used to hold and treat up to 4 patients when the department was at capacity.

We inspected this service on 5, 6 and 7 December 2023 (first visit) and did a follow up inspection on the 20 December 2023 (second visit). This was an unannounced full core service inspection looking at urgent and emergency care. We checked the quality of the services in response to being made aware of emerging risks within the department.

Urgent and emergency services

Requires Improvement 

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

- There was a risk that a deteriorating child might not be quickly identified. This was as staff working in the children's department had not all completed paediatric life support training, paediatric competencies, and children's safeguarding training.
- The layout of the department meant some patients were not visible to the staff responsible for their safety and welfare. However, this had been improved between our inspection visits.
- Non-clinical reception staff were expected to navigate patients to the minor injuries waiting area when they were not trained in clinical decision making.
- There were insufficient medical staff at consultant level and nursing staff to care for patients and keep them safe without using high numbers of bank, agency, and locum staff. The consultant numbers were significantly below the recommendations of the Royal College of Emergency Medicine and there was not a paediatric emergency consultant, in line with the requirements of the Royal College of Paediatric and Child Health.
- The environment and premises did not always keep people safe. The department was crowded at times, and this led to patients being cared for in areas not designed for patients, such as the corridor, and remaining on the back of an ambulance, for sometimes long periods of time.
- The service did not always ensure staff had updated life support and safeguarding training to keep people safe.
- Staff did not complete and update risk assessments for each patient or keep good care records. They did not identify or quickly act upon patients at risk of deterioration. The staff did not always recognise, assess, and treat patients in line with sepsis guidelines. There was a risk of a deteriorating patient not being picked up through ongoing clinical risk assessments. Staff did not always take regular patient observations in line with their local guidelines.
- Staff did not ensure all patients had their medicines on time and this included time critical medicines, and patients were not always offered regular food and drink.
- There was poor flow in the hospital due to capacity and delays in getting patients safely discharged. This meant many patients remained in the department for long periods of time. The service could not always be delivered to meet the changing needs of the local population. Services had evolved, patient numbers had increased, there were long waiting times and the service did not meet demand.
- Due to full and overstretched capacity in the urgent and emergency care system, patients could not always access the service when they needed it and sometimes had to wait a long time for treatment.
- There were poor and ineffective governance processes within the department. Although there was a basis for good governance, it did not demonstrate positive action and change, learning, improvement or provide assurance of safe and quality care. There was a lack of regular and consistent audit, risk management and learning from incidents. Where audits occurred, actions were not implemented to drive improvement.

However:

- The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection, although hand-washing was not always carried out when required. They kept equipment and the premises visibly clean.

Urgent and emergency services

- Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other**.** Key services were available 7 days a week.
- Staff mostly treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. There were pressures in the department due to high numbers of patients and a department that was no longer able to cope with demand and capacity. Staff worked their hardest to care compassionately for these patients in a difficult environment.
- Leaders were visible and approachable for patients and staff.
- Staff felt respected, supported and valued. There was a good teamwork-based culture in the department. Staff were clear about their roles and accountabilities.
- All staff were committed to improving services, even though they needed time and space to make this work. Following feedback to the senior leadership team after our first visit on site, improvements were underway to address in earnest many of the concerns we raised.

Is the service safe?

Inadequate 

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but not everyone had updated or completed it.

Nursing staff received and mostly kept up-to-date with their mandatory training, although the department was not quite achieving the trust target. The mandatory training was comprehensive and met the needs of patients and staff. Training was completed either during a face-to-face training day or through completing e-learning modules. Overall training completion figures for the staff in the emergency department (ED) was 80.3% which was below the trust target of 85%.

Managers monitored mandatory training and alerted staff when they needed to update their training. This was supported by the clinical practice development nurse whose focus was around education and training. All staff were within a team which was led by a band 6 nurse. They looked at their teams' training and encouraged staff to book onto training to maintain compliance. However, we were told this was not working well at present due to high pressures within the department. The staff were responsible for updating and booking onto their training themselves. Staff mostly chose to do their online training at home due to time constraints at work.

All staff had to be compliant with different levels of life support training depending on their banding or level. Healthcare assistants needed basic life support training; 53% had updated this this. Band 5 and 6 staff nurses needed immediate life support (ILS) and paediatric immediate life support (PILS) training; 79% of staff had completed ILS and 67% had completed PILS. The ED staff covered the paediatric area within the department overnight. The lack of specialty training available for ILS and PILS training was on the departmental risk register with several mitigations to manage the risk which included using trained staff in the children's team working elsewhere in the hospital. On our second visit, managers told us they had arranged two PILS training days specific for ED staff in January and February 2024 and booked staff onto these; this would significantly increase compliance.

Urgent and emergency services

Medical staff received and kept up-to-date with their mandatory training. Medical staff training showed an overall mandatory training compliance rate of 86.8%.

We saw 75.8% of staff had completed training on recognising and responding to patients with mental health needs and dementia. Staff could access support from specialist teams and nursing staff when needed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had updated or completed training on how to recognise and report abuse and not all staff were aware of who to inform if they had concerns.

Staff did not always update their training specific for their role on how to recognise and report abuse. The nurses and support staff training compliance was 79% for safeguarding adults level 2 and 68% for safeguarding children level 3. The compliance for medical staff for safeguarding adults level 2 was 87% and 82% for safeguarding children's level 3; the trust target for all levels was 85%.

There was a risk from staff looking after children overnight not having completed their level 3 safeguarding training and a risk of them not picking up all signs of abuse as a result, or acting upon them as required. There was no evidence of failure to identify risk, but the training was not at the right level to provide the safety net required. The band 5 and 6 nurses staffed the paediatric area overnight. However, managers told us they did not ensure these staff members had completed safeguarding children's level 3 training. We raised this with the trust, and managers created a 6-week plan for all nurses to have completed this training by the end of January 2024. They also created a database to identify who had completed the training to ensure only trained staff were allocated to the paediatric area. We saw on our second visit this was happening.

Most staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Most staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a referral pathway, however it involved an email referral and not all staff had an NHS email account. Some staff said they were not sure of the process and would inform the nurse in charge, and two told us they felt they needed more input and training on safeguarding. Safeguarding policies and pathways were up-to-date and accessible to staff through the trust's intranet. Staff had access to the trust's safeguarding lead for advice.

There was patient information on recognising signs of specific abuse on display within the department. Children identified as being at risk would be referred to the trust's safeguarding team and to the local authority. There was a system to make staff aware of known concerns about children and families.

Staff were aware of the Mental Health Act 2005 and the holding powers that doctors and nurses had. Staff got the advice from their mental health colleagues as required; they were available 24 hours a day, 7 days a week. Staff reported they were very supportive and easy to access. There was a pathway to follow for children who presented with mental health conditions with a clear risk assessment tool.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection, although hand-washing was not always carried out when required. They kept equipment and the premises visibly clean.

Urgent and emergency services

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact. Furnishings, such as chairs and flooring were wipeable and easy to clean. There was enough personal protective equipment (PPE) available for staff to equip themselves for the different levels of protection required within the department. Staff mostly followed infection prevention and control (IPC) principles including the use of PPE. Hand hygiene sinks, hand gel and PPE were available throughout the department. Staff were bare below elbows for effective handwashing and wore surgical masks as currently required by policy. Staff wore disposable gloves and aprons, when required, for example when assisting patients with personal care. However, we noted a lack of regular handwashing when observing staff delivering care and treatment on both our first and second visits.

Managers audited staff compliance with IPC practices including hand hygiene and cleaning. Hand hygiene audit results for August and September 2023 were 100% and yet decreased to 50% for October 2023. They audited whether staff were bare below the elbow, and they were 87% compliant for August and September 2023 and increased to 100% compliant in October 2023. However, there were no action plans associated with these audits. They were either blank or did not have an expected action or completion date.

The department took action when risks or issues around IPC were identified. The department had undergone an external audit in September 2023 which showed poor infection control practices. Following this, managers organised a project team for six weeks to resolve this. The team completed a deep clean of all areas of the department and the maintenance team repaired areas which needed improving such as ceiling tiles and other IPC risks. The team did a full stock take and decluttered areas which prevented good cleaning and increased their auditing to weekly. They also developed a new cleaning checklist and reviewed the role of the housekeepers. Since then, they had an assistant practitioner who worked regular supernumerary shifts with the focus of improving the IPC and educating staff on the cleaning. They had previously received 2 stars in their IPC audit. This had increased to 4 stars on 1 December 2023 and the previous week was 5 stars.

The service generally performed well for cleanliness although actions taken when results were not optimal were not in evidence. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audits were completed monthly by the IPC nurse looking at the whole environment. The results varied between 50% and 75% for August to October 2023. However, there was no action plan to increase compliance. There were two regular domestic staff who cleaned the department between 6am and 8pm. There were no cleaners in the department at night and any cleaning was carried out by the nursing team and support services assistants. However, due to the increased patient numbers within the department, this was not always possible. This meant the cleaners spent the first part of their shift catching up on the cleaning from overnight. The cleaners were audited weekly, and failings were addressed immediately; we saw evidence of this within the cleaners' records.

Guidance was available for staff in the trust's IPC policy. The policy described all protocols required to maintain a good level of cleanliness, infection control and hygiene. The staff could get further IPC information from the infection control nurses who attended the department weekly. We were told they were very accessible and approachable.

Staff were not all compliant with their training in IPC and hand hygiene. Training data showed 62.5% of nursing staff and 71% of medical staff had completed IPC level 2 training. This was below the trust target of 85%.

Side rooms were available for patients when isolation was required, and staff told us how they would manage the risks associated with transmittable infections. This was in line with best practice.

Data showed there had been no infection control cases reported in 2023. This included E-coli, MRSA and MSSA bacteraemia.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The design of the environment did not always meet national guidance and did not always allow good patient flow. The department was small and cramped for the number of patients it saw. This meant it was cluttered and patients were being cared for within areas which were unsuitable, such as the corridor.

There were some risks from the environment in the children's area not being fully secured or free of manageable risks. The area was located next to the adult department but operated as an independent unit, thus separating the children's and adult's emergency care pathways as recommended by national standards. It had two trolley bays and two rooms, one of which had two trolleys. There were also seats for patients who were waiting. Of these rooms, one had a door which was not secured and opened immediately into the ambulance bay outside. The other room had unsecured access to the main waiting room. One of these rooms had consumables in which could pose a risk to children such as needles, scissors, and sharps bins.

On our second visit, we found the paediatric rooms had been made secure and safe. The two exit doors in the clinical rooms were locked with no unauthorised access into the area in or out. The team working in the area were able to unlock the doors from inside easily if needed in an emergency or for required access. The clinical areas had also been decluttered from medical or other equipment that might pose a risk to children or others. However, we saw there was no emergency call bell within clinic room 1. This meant in an emergency, staff could not be alerted quickly.

The service was taking steps to limit delays for patients arriving by ambulance and ensure patients were safe, although there was not always oversight of patients held in spaces not intended to provide care or treatment. The department was working hard to limit as much as possible the delays faced by ambulances when handing over patients. However, this often resulted in patients being held in a narrow corridor on a trolley for indeterminate lengths of time and with limited oversight. Also, relatives or carers accompanying the patient often had nowhere to sit or made the area crowded and harder to navigate when the corridor was not designed for this purpose. We saw all four internal trolley spaces in the corridor were in use constantly whilst we were on site over the three days. There was a nurse who was assigned to look after the patients in this corridor, but they were required or needed to step away at times.

In November 2023, 556 patients were cared for in the internal corridor and 1,313 were cared for in the pitstop corridor chairs. In order to improve the oversight, we recognised on our first visit was not ideal at all times, a healthcare assistant was delegated to look after and oversee the patients in the corridor 24 hours a day alongside the nurse. We observed the care and treatment being carried out with kindness and the patient receiving an apology for the situation from the nurse, despite there being difficulties maintaining privacy and dignity for patients.

There was poor visibility of patients for their safety and welfare in waiting areas, although steps had been taken to address this problem after our first visit. The main walk-in waiting area for patients and those with them was mostly not visible to the reception staff and there were no CCTV cameras to monitor patients. Staff told us they were due to have a mirror fitted to increase visibility for reception staff, but this had not happened.

However, following our first visit where we highlighted the safety risks from poor visibility, a nurse coordinator now oversaw the main waiting room alongside a healthcare assistant and was based in the area. They supported the patients waiting with regular communication and safety and welfare checks. This was supported 24 hours a day to provide

clinical safety to patients waiting for further procedures or triage. The only concern for the nurse overseeing the patients in the waiting room was with the number of patients to support. At the time of our visit, they were looking after up to 15 patients who were required to have some form of check every hour. We were told this was almost impossible to achieve safely with the constant flow of patients.

The service had a 'pitstop' area and a 'fit to sit' area. The pitstop was used to assess and triage patients who were either brought in by ambulance or were walk-in. This was staffed by three nurses, a healthcare assistant and a senior doctor at all times. These patients were moved to an area within the department following assessment. However, often due to the lack of space, this could be back into the waiting area or onto one of the nine chairs outside the pitstop called 'post pitstop'.

The 'fit to sit' area was an ambulatory area with nine recliner chairs. This had limited space and was mostly used for patients waiting for a cubicle to become free in majors. However, there was no criteria for staff to follow for patients who were appropriate to be placed in this area. Due to the lack of cubicles available, patients often remained in this area for long periods of time. For example, we saw on the 7 December 2023, an 89-year-old patient had been in the department for 19 hours and had been in a chair overnight. We also saw cardiac patients who needed monitoring were in the 'fit to sit' area for long periods.

Following requirements from NHS England to provide additional support to EDs, the trust had established a medical same-day emergency care (SDEC) service and a frailty SDEC service. There were plans for a surgical SDEC service to open on 18 December 2023, but this had been affected by strike action by junior doctors. The SDEC was open from 8am until 8pm and could take up to 24 patients. It had strict criteria to accept patients which included a National Early Warning Score (NEWS2) of under four and the patient being independently mobile. It was staffed by two advanced nurse practitioners, two nurses and a healthcare assistant.

Most patients directed to SDEC were discharged the same-day and could be asked to come back for non-urgent investigations usually the following day. For example, we joined an 11am doctors meeting where it was decided a patient from majors could be discharged home and brought back into SDEC the following day for further tests.

Non-clinical reception staff were required to navigate patients to the minor injuries waiting area when they were not trained in clinical decision making. The layout of the department meant there was no visibility of the minors waiting area and a risk a patient could deteriorate, and staff would not be immediately aware. Patients who attended with suspected minor injuries were sent to the minors area which was located off the main waiting area. This was staffed by two emergency care practitioners from 8am until 9.30pm, 7 days a week. The team saw between 15 to 20% of the patients who attended ED. If patients attended with a minor injury when the department was closed, they were seen by the doctors in majors or directed to see their GP.

There had been a lack of consistent checking of emergency trolleys and the equipment they carried. However, on our second visit, all the trolleys with equipment used for resuscitation were now locked with a tamper proof seal and most had been checked each day. On our first visit it was noted there were multiple gaps in the checking process. For example, for one of the trolleys, the daily check was completed for 18 days in September 2023, 19 days in October 2023 and 18 days in November 2023. The monthly check was not done for two out of three of these months. On our second visit we noted this had been addressed and there was only one gap in checking in the time since our previous visit. All three trolleys had a tamper proof seal, but on our first it was broken for two of the trolleys which were both kept in patient cubicles. This was resolved for our second visit and now a priority for the senior nurse.

We checked at least 30 consumables across both visits and found two out of date; these were disposed of immediately.

Urgent and emergency services

Staff could not always access equipment required for emergency situations quickly. There were no trauma packs or haemorrhage packs within the resuscitation room. There was a chest drain drawer, but this mostly contained dressings. Staff told us equipment had been removed when the area was 'decluttered' and not replaced.

There were insufficient treatment, assessment areas and waiting room space to accommodate all the patients attending the department. Patients were often held on the back of ambulances until space became available for review. All ambulance patients were seen in pitstop. Walk in patients were booked in at the main reception area. After booking in, patients were directed to wait in the main waiting area, children's waiting area, or minors to await triage. All patients were triaged in the pitstop area or children's area and were asked more details about their condition and directed to the appropriate area to wait or commence treatment.

The mental health room was not a suitable environment for assessment. Mental health assessment rooms should follow the guidance of the Psychiatric Liaison Accreditation Network and best practice. However, the managers were aware of the risks. It was on the departmental risk register and there were plans to make improvements. The designated mental health room was a cubicle within the majors' area. The assessment room had only one exit point, when it should have two doors, and there were potential ligature points such as sink taps. The door allowed patients to lock themselves in from the inside or lock staff in preventing escape and it did not open outwards. There was no access to a toilet in the department which was ligature safe. The service was due to recomplete a full mental health risk assessment of the environment in January 2024.

The mental health environment was poor for patient safety, and staff did not always act to keep people safe. We spoke to a patient who had presented with mental health concerns, and they said the staff did not understand mental health and assumed drug or alcohol usage as the reason for their mental health decline. They felt 'invisible' and were not checked on often. They said the environment was poor as they were in a room without a window, and this made them feel anxious.

Patients could not always reach call bells and staff did not always respond quickly when called. We saw a number of patients who did not have a call bell in reach and all patients who were cared for on the corridor did not have a call bell. At times, patients or their families would need to shout when they needed assistance. We saw on a few occasions there were patients cared for in the corridor who shouted for help and staff walked past them and did not attend them. We fed this back to the managers who delegated a healthcare assistant 24 hours a day to assist the nurse looking after these patients to always ensure oversight.

The trust had a protocol for how to respond to a patient who had left without being seen or while awaiting treatment. If a patient took the decision to leave the department, and staff were concerned for their welfare, they had a process to follow with the other emergency services (ambulance and fire services) to endeavour to get help to the patient. Contacting the police was a last resort or if there was a fear for the patient's safety or that of others.

Clinical waste was disposed of safely using separate designated waste bins for general and clinical waste and sharps buckets for sharp instruments. Safe disposal of waste was audited monthly, and the department was consistently 100% between August and October 2023.

Assessing and responding to patient risk

Staff did not always assess and manage risk well. There was a risk that a deteriorating patient was not identified and acted upon quickly as staff did not always complete risk assessments for each patient promptly; this included regular observations. There was a delay in assessment and treatment for some patients when the department was full due to the lack of flow through the hospital.

Urgent and emergency services

Staff did not always complete risk assessments for each patient on arrival, using a recognised tool, in a timely way. Medical staff did not routinely assess patients while on the ambulance. Whilst all patients were handed over on arrival, some patients waited several hours before being admitted into the department.. However, if the patient was deteriorating and there was no bed available, doctors would review the patient on the ambulance and start any treatment where possible. There was no protocol staff used to review the patients who were waiting on ambulances for longer periods of time.

The triage process followed evidence-based practice and patients were graded in accordance with the seriousness of their injury. There was a colour-coded scale on the computer programme to give a visual appearance of those patients who would need a more urgent review. The time the patient had been in the department was also colour coded to indicate those waiting longer than the national standard waiting time and give a visual warning to staff about delayed treatment, particularly when both more high-risk trigger colours were indicated. On occasion, when a patient was reviewed first by a doctor the colour coding system was not effective as triage was a process not required to be followed.

We looked at 12 sets of records and found 3 out of the 12 patients did not have a completed triage. If the patient was seen by the consultant, they did not always have a formal triage completed. This meant it was not always easy to determine the patient's clinical priority and patients were not always seen in order of clinical need, they were mostly seen in order of attendance. When asked, staff were not always aware of who was the sickest patient in the department.

There were standard templates in the triage area to follow for consistent processes for specific conditions. For example, the early pregnancy triage tool triage process described what needed to be done in each case; any warning signs to escalate to a clinician; what tests or examinations would be required; and what to do in emergency situations, such as high early warning scores.

In the main waiting area, the department used a process of asking patients to sit in either red chairs, if they had not been triaged, or blue chairs if they were waiting for the next steps. With a crowded waiting room, it was unclear whether this was helpful. One patient we met who had been triaged was anxious they could not find an empty blue chair for themselves and their relative to use, so had taken a red chair.

Walk in patients were not always assessed or given treatment in a timely manner. There was a risk that unwell patients could be left in the waiting area without triage for a long period of time without staff knowing the patient was at risk of deterioration. For example, on 7 December 2023, a consultant told us a patient was in the waiting room overnight for nearly three hours prior to being triaged. As the time to initial assessment increased, there was no clear escalation plan of how patients would be triaged, and risks could be mitigated. Following our second visit, managers had assigned a nurse to the waiting room who could also assist in triage if delays were increasing. Otherwise, patients were reviewed within pitstop in time order and there were no systematic triage processes in operation.

Triage performance had improved. Standards set by the Royal College of Emergency Medicine (RCEM) state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. Not all patients were seen for a clinical triage within 15 minutes of arrival. However, the department's performance for triage within 15 minutes had improved from 40 minutes in August 2023 to an average of 24 minutes at the time of inspection. Senior staff reduced the risks associated with delays to triage by allocating experienced nurses to work in triage.

There was a risk that the consultants' time within the pitstop area was not being best used. We found there was clear ambition to have a senior doctor managing pitstop 24 hours 7 days a week cover. This allowed for early investigations and early senior decision making and specialty referrals, as well as the ability to discharge patients after early senior review. The model of senior doctor assessment was a recognised RCEM ED assessment. However, the lack of a separate

triage for walk in patients meant there was a risk that "well" patients were seen and assessed by a senior clinician before a sicker patient, merely because they arrived earlier. There was also a risk that less experienced junior doctors over investigated less acute patients and low acuity patients were being seen by a consultant which may not always be the best use of resources.

Staff used a nationally recognised tool to identify deteriorating patients, but they did not always complete observations in a timely manner. We saw NEWS2 were not always completed regularly and patients with high NEWS2 (indicating risk) were not reassessed or monitored hourly in line with guidance. For example, on our first visit, we saw a patient had arrived with a respiratory condition. Their first set of observations were taken at 10.42pm on 6 December 2023; they were not then taken again until 6.45am on 7 December 2023. We looked at 12 sets of records and found in all 12 records observations were not recorded hourly as required. Senior nurses told us NEWS2 should be completed hourly. Patients remained in the department for long periods of time and at times had periods of between 4 to 6 hours without a NEWS2 being recorded. We fed this back to the trust, and senior staff told us the clinical skills trainer would provide focused NEWS2 competency and refresher training which would commence on 11 December 2023 and continue throughout January 2024. During our second visit, we were told this had started happening. Managers also reminded the staff through their daily safety huddles about the importance of completing and recording clinical observations.

Managers were not aware of the poor compliance with completing observations and the risk of staff not detecting a deteriorating patient. The service did not audit NEWS2 completion. However, following our feedback the managers took action to improve compliance. They completed an audit of 8 sets of notes which showed a slight improvement with completion of observations. It showed 4 out of 8 patients had their observations completed every 1 to 2 hours. Actions to improve compliance included regular auditing and learning was to be cascaded through safety huddles.

During our second visit, we reviewed 4 sets of notes. We found the frequency of observations had improved in the daytime, but they were still not completed hourly overnight. One patient went 6 hours without any observations. This was again fed back to the managers. We were advised there would be weekly audits of the documentation with results shared with staff where the standard was not met. Following our second visit, we were sent an audit which showed an improvement in frequency of observations for patients with a NEWS2 of 5 or above. For example, the average time between observations for a patient with a NEWS2 of 8 in November 2023 was 75 minutes; this had decreased to 57 minutes between 15 December and 28 December 2023. Connected to this audit, managers had developed a standard operating procedure for patient observations. This gave further guidance about when staff should be taking observations and when to escalate to the doctors. Data showed that at the time of our inspection 81% of nursing staff had completed NEWS2 practical competency training and 83% had completed their e-learning training although this was below the trust target of 85%.

Staff told us they did not have time to complete observations and management recognised this. Following our first visit, they put a further healthcare assistant 7 days a week allocated to the area of most pressing need as identified by the nurse in charge. They assisted with NEWS2 observations which meant the nurses had more time to complete other tasks.

The staff in the children's area completed paediatric early warning scores. The trust sent us an audit of five sets of records which showed these were completed in a timely manner.

Not all staff had a good awareness of assessment and treatment of sepsis (the sepsis 6 bundle) and did not always act promptly to reduce the risks associated with sepsis. We looked at compliance with the sepsis 6 bundle within patient records.

Urgent and emergency services

Sepsis 6 compliance was audited in April 2023 by the medical team. They looked at 46 patients who identified as septic between January to February 2023. They found the average time to be reviewed by a doctor was 6 hours and 53 minutes, the average time for the first dose of antibiotic to be given from the time of presentation was 7 hours 54 minutes. Following the inspection, managers completed a sepsis audit which showed 5 patients out of 10 scored as red flag for sepsis. Of these, two patients were not appropriately identified in the screening process. No bundles were recorded on the electronic system for the patients. Results showed four out of five patients received antibiotics with the mean time to prescription of 2 hours and 16 minutes and mean time to administration of 3 hours and 9 minutes.

Actions from this audit included training staff on the screening tool in triage, promoting the use of sepsis bundle in triage and to re-audit in January 2024.

On our first inspection visit we saw nine out of 12 patient records had a completed sepsis screen on assessment. We found three of these nine patients were given a diagnosis of potential sepsis. Of these three patients, two were given antibiotics but neither were given within 1 hour as required, and the sepsis 6 bundle was not initiated or completed. We raised this with senior staff who told us they intended to do focused teaching sessions and remind staff in their daily safety huddles about the importance. On our second visit, we saw posters around the department highlighting sepsis and staff had started using the sepsis bundle in paper form. The computer systems had been updated so when a patient scored a NEWS2 of three or higher, staff were prompted to complete a sepsis screening tool. This was one of their triggers for assessing patients for sepsis.

A clinical dashboard had been developed to monitor NEWS2. This dashboard highlighted if any patient in the department had a NEWS2 of 5 or higher, if their observations had been completed within the hour, and whether the sepsis screen had been completed and antibiotics given. This meant the nurse in charge had better oversight of these patients. On our second visit, the dashboard showed all patients with a NEWS2 of 5 or higher had up to date observations taken within an hour. Staff told us sepsis had been discussed widely in safety huddles and training sessions had commenced.

The service sent a further sepsis audit which was completed on 22 December 2023. This showed four patients who had a NEWS2 of 5 had been correctly identified; this was an improvement from the previous audit. All patients received antibiotics with the mean time to prescription of 37.5 minutes which had improved from 2 hours 16 minutes in the previous audit and most other elements of the sepsis 6 had been completed. However, there was no sepsis 6 paperwork that had been completed. Staff planned to reaudit in January 2024 and promote the use of sepsis bundle paperwork in triage. Following our first visit, the managers developed a new standard operating procedure to identify and manage patients with sepsis within the department.

Staff were not always aware of specific risk issues due to the lack of completion of some assessments. We were not assured that pressure area care and tissue viability was managed well within the department. We saw some risk assessments were completed well, such as falls risk assessments and frailty scores. However, not all risk assessments were always complete. Staff used the ‘Anderson’ risk assessment tool to look at the patient’s risk of developing a pressure ulcer; it should be completed within the first hour of the patient being in the department.

We looked at 8 sets of notes and found the Anderson tool had not been completed in 5 out of 8 sets of notes. Two of these patients were in their 80s and stayed overnight on a recliner chair in ‘fit to sit’ without their pressure areas being checked. Where it had been completed in three sets of notes, they were not completed within an hour of admission; 2 of them were 11 hours after admission to the department. We saw on 7 December 2023, a patient in ‘fit to sit’ was noted to have a red sacrum at 2.45am and again at 9.46am but there were no measures to reduce the risk of this developing into a pressure ulcer.

Urgent and emergency services

Staff did not always act to prevent or reduce risks. Nurses told us they did not routinely use fluid balance charts even where it was critical to the patient. For example, fluid balance was not always recorded if the patient had a catheter or sepsis where input and output was indicative of a patient's condition. We saw examples of this when we reviewed patients' notes. Following our second visit, we saw posters in the department prompting staff to complete fluid balance charts. Paperwork had been reorganised to make it more accessible to the nurses and teaching and training had started. Managers were going to audit compliance through the documentation audit.

Patients were not always been routinely monitored through regular observations. Observations were carried out sporadically and inconsistently. Nurses documented them in different places, and meant it was hard to determine whether it had been undertaken. One nurse told us it was documented in the 'patient safety checklist' and another told us they documented it within the nursing notes. All notes we checked showed regular observations did not occur every 1 to 2 hours. At our second visit, we were told that the system had been updated to mandate the patient safety checklist completion with each set of observations. The compliance to the patient safety checklist was not covered in the newly developed documentation audit, but it was added while we were on site.

Initially there was no clinical oversight of the waiting room which meant there was a risk that a deteriorating patient could be missed. This was improved following our feedback and following the first inspection visit, the trust added an extra nurse to work with the 'front door' team of nurses to do regular observations of the waiting room. They were also supported by a healthcare assistant from 10am until 10pm. Staff told us the waiting area felt safer and felt reassured knowing there were staff observing the patients.

Patients were, at times, left unattended who were high risk within the majors area housing bays 11 to 15. Staff told us it was a risk to patient safety when there was only one staff member allocated to the area as they were not able to always remain in the bay. For example, when they transferred patients to other areas within the hospital. The area was intended to be staffed by a band 5 nurse and healthcare assistant. On 6 December 2023, we saw a patient with dementia nearly fall out of bed when the nurse left the bay unattended. They were found by another member of staff who walked through the area. The nurse had transferred a patient to another area which had left the bay unattended. We were told not all patients within this bay were always triaged and could be brought from the ambulance into this area. They would bypass the pitstop area in certain busy times where they would otherwise be triaged. We were told that if a patient had not been triaged within 20 minutes, the staff covering the area would complete this themselves.

Patient risks for developing venous thromboembolism (VTE – blood clots) were assessed. Patients should be risk assessed for developing VTE when remaining in the department for longer than clinically intended and we saw that happened. We looked at 3 patient records who had been within the department for over 14 hours and they all had a completed VTE risk assessment and appropriate preventative treatment prescribed. The trust were also reviewing its VTE policy for routinely undertaking VTE risk assessments in the ED due to the increasing length of stays for patients.

There was good support for adults with a mental health crisis. The service had 24-hour access to mental health liaison and responsive specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had good support from the mental health team who advised and assisted staff with mental health issues. In November 2023 the average time to referral was 2 hours and 53 minutes.

Staff did not always have a good understanding of mental health and consider the ongoing risks for mental health patients. They did not always ensure the patient was getting the right level of care required. We observed a patient who was in the mental health assessment cubicle in majors on 6 December 2023 who had attended with self-harm concerns and had self-harmed within the waiting area. They were visibly upset. We saw the patient try to get staff attention and

was ignored. There was a lack of interaction from staff, the patient was not checked on by staff regularly and risk assessment not completed within a timely manner. We asked to see the risk assessment. This colour coded the patient's risk which led to enhanced observations if deemed appropriate; this had not been completed for this patient. This meant there was a risk that the patient was not observed frequently enough and would cause further harm.

There was good support for children with mental health needs. The paediatric area had access to the children's and adolescent mental health service and used a risk assessment to assess children presenting with mental health issues. Staff were able to get support from registered mental health nurses within a few hours where required to support these children.

Staff did not always share key information to keep patients safe when handing over their care to others. Patients who were transferred to a ward from the department did not have a written handover completed. The nurse did this verbally and printed off clinical information from the computer system as the ward nurses did not have access to the ED electronic system. Patients who were discharged to a care setting were not sent with a discharge letter or a transfer document and we were told that often a verbal handover was not given. This meant care home staff were not always aware of what had happened to the patient while they were in hospital.

Not all patients were wearing their hospital-issue wristbands to provide identification and prevent communication errors. The department used a system which provided patients with identification wristbands on arrival. We noticed 4 patients had no wristbands on and 5 patients who were carrying their wristbands rather than wearing them and one was being carried by a parent and not the young person. We saw the lack of wristbands on patients was discussed in the November 2023 divisional quality governance meeting including concerns that medicines were given to patients with no wristbands. There was no action from the meeting to improve compliance with wristbands.

There was good oversight of patients for the senior team in the department. Each computer in the department had access to a patient management screen which displayed an overview of patients. It showed the length of time each patient had been in the department, or on an ambulance, or were waiting for triage, or treatment. Managers saw where the greatest risks were and moved staff and resources around accordingly. A patient flow facilitator was based in the department every day and liaised with site managers, matrons, and doctors to access beds for patients as soon as possible. Risks were discussed at regular bed meetings every day; these were held four times throughout the day.

Nurse staffing

The service did not always have 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 reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe and complete basic tasks at times, although measures had been taken to improve this. Staff told us there were not enough staff to care for the number of patients and they felt it was unsafe as they did not always have time to deliver safe care. This was evident with some of the issues found including lack of timely observations, poor risk assessment and poor record management. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, but this did not meet the demand of the patients in the department. The Royal College of Nursing (RCN) Nursing Workforce Standards within a Type 1 ED require the nursing workforce to be determined by looking at a number of things. This includes using a baseline emergency staffing tool (BEST). The BEST ratio for low dependency patients is one nurse to 3.5 patients. There were times where there were three nurses within pitstop who had more than 30 patients to look after; they were not always low dependency patients.

Urgent and emergency services

Nurse staffing levels had been established as 14 nurses and 5 healthcare assistants per day shift and 13 nurses and 5 healthcare assistants at night. The number of nurses and healthcare assistants matched the planned numbers on the day we inspected. Managers had increased the numbers by 2 nurses day and night in September 2023 following an increase in incidents in the 'fit to sit' area. There were six band 7 nurses sisters who worked within the department to support the nurses. They were not counted in the nursing numbers (supernumerary) and enabled therefore to step in when there was sickness or support for staff or patients was required. There was a matron in charge and visible within the department.

Some nursing staff told us they did not have time to fulfil their roles. We saw examples of this where medicine was overdue by three hours and patient observations were not completed in a timely manner. We raised this with senior staff in the trust who were responsive. They added a nurse and two healthcare assistants to the department 7 days a week to support the team. During our second visit, staff told us the increase in staff had improved the care for the patients.

The service had 6 emergency nurse practitioners (ENP) who worked autonomously within the minor's department; there were no vacancies within this area. Most shifts had 2 ENPs who covered the department from 8am to 9.30pm.

There were 5 advanced care practitioners who worked throughout the ED. They worked staggered shifts throughout the daytime and reviewed patients alongside the doctors.

There was a high vacancy rate and a relatively junior nursing team needing extra support. The service had a vacancy rate in the department of 21.4%; we were told this were for band 5 nurses. The trust had a rolling advert out to recruit band 5 nurses. Meanwhile, the staffing gaps were covered by regular agency and bank staff. They had recruited 13 overseas nurses who required support and training during their preceptorship year.

There was a risk due to not all ED staff nurses looking after children overnight having completed paediatric immediate life support (PILS) training, safeguarding children's level 3 training and paediatric nurse competencies. This led to a potential risk of them not picking up a deteriorating child and acting appropriately. There was no evidence of failure to identify risk, but the training was not at the right level to assure safe care at all times. Also, managers told us they did not have a process to ensure these staff members had completed the appropriate training. We highlighted this with the trust who put in immediate mitigations to ensure that from 8 December 2023 only staff who had completed PILS training, safeguarding level 3 and the RCN competencies for paediatrics were allocated to cover the paediatric area overnight. Data shared after the inspection showed 14 members of staff out of 73 were compliant with all three. Where it was not possible to provide a fully trained nurse, the trust's paediatric ward would provide a nurse, or the nurse's training would be risk assessed. For example, it would be deemed low risk if the competency or training was out of date by a month.

We were informed by senior managers after the inspection of a plan to train all staff over the following 6 weeks; they aimed to have all staff trained by the end of January 2024. They had also assigned PILS as a mandated competency within the roster. This meant when they were completing the staffing rota, they were required to ensure during each night shift there was someone who was PILS trained to cover the paediatric area. During our second visit, the managers told us they had linked up with the paediatric practice educator who was going to provide drop-in learning sessions for the nurses as well as assisting with signing off competencies for the nurses where able. The paediatric area was staffed in the daytime by an experienced paediatric nurse and healthcare assistant who were provided by the paediatric ward during the hours of 7.30am and 7.45pm, 7 days a week.

There was a reducing turnover in nursing staff. The department turnover of nursing staff had decreased from 13% in September 2023 to 9.9% in November 2023. This was below the trust target of 10%. Managers told us they had a turnover of international nurses who had completed with 12-month preceptorship programme in September 2023 and had moved to a different area. They had recently recruited more international nurses into their team who were supported by a buddy team.

The service had fluctuating sickness rates. The sickness rate for September to November 2023 was an average of 5.7%. The sickness rate for qualified nursing staff fluctuated between 0.7% and 7.9% in 2023; the trust target was 3.5%. The sickness rate for healthcare assistants had considerably decreased in 2023 from 18% in January to 1.6% in August 2023.

The service had a high but reducing number of bank and agency nurses on shift. Agency nursing numbers had decreased from 31% in September 2023 to 25% in November 2023. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Most agency staff were regular staff who knew the department and were experienced ED nurses. There was an average over the same time period of 9.2% of shifts which were covered by bank nurses. Of these shifts there were 5.8% unfilled shifts in September 2023 which decreased to 2% of shifts unfilled in November 2023.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There was a significant shortfall in the recommended number of consultants working in the service, and no paediatric emergency medicine consultant. However, managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe and relied on regular locum consultants to reduce the risks and increase the safe staffing levels within the department. There were 3.2 full-time consultants employed. The department had three consultants per day, working staggered shifts to provide senior presence from 8am to 7pm, Monday to Friday. There were two consultants at the weekend providing cover until 9pm. This did not meet the RCEM recommendation of 16 hours consultant presence every day. The trust had recently appointed one of their regular locum consultants for a substantive post commencing in January 2024 and were interviewing for another two substantive posts. The senior leadership team had submitted a business case to increase their consultant cover to ten full-time consultants which would ensure cover in line with RCEM recommendations; this was awaiting approval by the executive board. The consultant vacancy rate was on the departmental risk register. This had not changed since our previous inspection where we found consultant levels did not meet the RCEM requirements. The control measures included long term locum cover and additional hours covered by ED consultants. The low consultant numbers meant quality improvement work was delayed and it impacted on the department's ability to have emergency medicine trainees due to the supervision required.

Not all medical staff had completed advanced life support training for adults and children which meant there was a risk of them not recognising a deteriorating patient and not acting appropriately. There was no evidence of failure to identify risk, but the training was not at the right level to assure safe care at all times. Managers were unable to ensure every shift had a senior doctor who had advanced paediatric life support and advanced life support due to the low staffing levels. We saw 54.2% of medical staff had completed either immediate life support or advanced life support and 4.2% had completed the equivalent for paediatrics. To mitigate the risk, managers relied on support from other trained staff in the hospital. There was a paediatric consultant who provided an on-call service and on-call intensive care

anaesthetists; this was arranged to provide further paediatric advanced life support (ALS). Additionally, the hospital's medical on-call team who attended the department when requested were all ALS trained. We were told there was a plan to provide training to doctors to ensure adequate life support training was available. However, this risk was not on the departmental risk register.

An on-call consultant covered the out of hours period 7 days a week. Each night shift had two specialist doctors and two junior doctors who worked alongside the consultants. There were advanced care practitioners on throughout the day who assisted the medical staff with reviewing the patients. There was always a junior doctor assigned to paediatrics 24 hours a day, with a specialist doctor assigned to support.

The service had high but reducing vacancy rates for medical staff. There was an overall vacancy rate of 16.3%; 40% of this was consultants and 20.2% was middle grade doctors with a total of 5.23 full-time equivalent staff vacancies.

The service used high levels of locum doctors due to a high number of vacancies. There were a high number of unfilled shifts although this fluctuated and was reducing. Managers told us they could employ locum doctors without too much delay when they needed additional medical staff. They used reliable regular locum staff who they said provided a good quality of cover. Managers made sure locum doctors had a full induction to the service before they started work. We spoke to a locum registrar who said they had received a good induction and found it a very supportive environment to work in. The service used 250 hours of locum time in September 2023, and this increased to 613.5 in November 2023. These hours were for speciality doctors and consultants with 553.5 hours used for specialist doctors in November 2023. The reason for this high number was 3 permanent doctors left over this time period and there were doctors' strikes. The service had a high number of unfilled shifts. In September 2023, there were 19% of shifts unfilled but this reduced to 6.75% in November 2023.

Sickness rates for medical staff were lower than the trust target of 3.5%. The sickness rate for medical staff between September to November 2023 was 1.1%.

There was access to senior medical staff for training and development. The junior doctors had focused training every three weeks for an afternoon. Speciality doctors had teaching on Friday afternoons. We were told this was mostly well attended. We spoke to a junior doctor and a foundation year doctor who both confirmed they had regular programmed time for teaching and training and had received induction when they started in the department. They were satisfied with the way the rotas were managed and they both told us they had access to senior staff when they needed advice, including out of hours.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not clear and were not always completed. However, they were stored securely and easily available to all staff providing care.

Patient notes were not always comprehensive. We looked at 12 records and found hourly observations, checklists, risk assessments and fluid balances were poorly completed in all 12 notes we looked at. All notes were electronic but a number of different systems were used.

There were ineffective care plans in the system for patients needing to stay in the department for longer periods due to delays in discharging to wards. There was an electronic system for ED which was designed for patients who remained in ED for less than four hours. However, due to the lack of flow through the department, patients were staying for long periods of time while waiting for beds but the systems were not programmed to support care and treatment for long stay patients. Staff did not have appropriate long-stay risk assessments for patients who remained in the department or

appropriate medicine charts. This meant risk assessments and medicine management relied on the nurse remembering to complete them rather than a system prompt. Once the patient moved from to the wards, their records were held on a different computer system. When patients transferred to a ward, this lack of shared systems meant there were occasional delays as staff had to print all the patient's notes prior to transfer as the wards could not access the emergency department system.

The trust were aware there was a problem with the lack of a joined-up system and were planning on moving the emergency department across onto the system used in the rest of the hospital. However, this was not due to happen until at least the end of 2024.

Staff told us the patient record systems were difficult to use and inconsistent. We were told it was difficult to see what the plan for patients was, their clinical needs, when a patient had been reviewed by a speciality and what care had been completed. Staff were aware basic checks did not get well documented all the time.

Managers were not aware of the omissions we found within the patient documentation as they did not audit their medical records. Following our inspection, they completed an audit on the documentation. They found the same issues we had found including lack of regular observations, patient safety checklists poorly completed, poor sepsis 6 completion and implementation and a lack of fluid balance charts. As a result, they told us they were going to audit the patient records monthly and implement changes to improve the quality of the records.

Records were stored securely on a computer system. All staff could access notes easily with their own login and password. All agency staff were given secure access to the systems while working in the department.

Medicines

The service did not use systems which enabled them to safely prescribe, administer, record and store medicines.

Due to a poor medicines management system, staff were not always able to follow the systems and processes when safely prescribing, administering, and recording medicines. Not all medicines were given on time and records were poor. An electronic recording system was used that was specific to the ED. Although it was a good visual tool for staff, it did not provide the required medicines information necessary to ensure the safe prescribing and administration of medicines. It was not always easy or clear to see if patients had been given their medicines. It did not link in with any other digital platforms which were used trust wide. For example, the trust used an electronic prescribing and medicines administration (ePMA) system however, ePMA was used within the ED and only used once patients had been accepted by a specialty. This meant there was a gap in up-to-date medicines information for patients.

There was a particular impact for patients prescribed time critical medicines if they were not prescribed or administered on time. There was no alert on the system for these medicines. For example, on 6 December 2023, we saw a patient had been prescribed antibiotics for sepsis at 1pm and they had still not been given by 3.40pm. They were prescribed on the ePMA system which did not alert the nurse they were overdue. It relied on the nurse being aware of the prescription and the time it was due.

The system also allowed for medicines to be prescribed without documentation of up-to-date allergies or other medicine history. We were told the trust was aware and were in the process of updating and implementing a new system into ED. This was not on the ED risk register despite the managers being aware of the risks associated with the use of different systems within the department.

Some patients had not been administered their medicines at the prescribed time. We saw three patients in the pitstop area had not had their medicines administered an hour after they had been prescribed. Of these patients, two of them had not received their pain relief and one patient had not received medicines to help a respiratory condition. We were told it was due to nurse capacity and there had been no time to administer the medicines. We saw medicines were given with no drug history or allergies recorded in the notes.

Patient group directions, a set of authorisations for non-medical prescribers to be able to give certain agreed medicines, were available and up-to-date within the department.

Medicines records were not always accurate or up-to-date. There was a risk that medicines were forgotten by either the nurse or doctor as the online system did not include a medicine chart. Each medicine had to be individually prescribed when needed. Documentation of medicines administration including routes of administration and specific times of administration were not always completed on the medicine records reviewed. It was difficult to follow a patient's pathway regarding prescribing and administration.

Information on missed doses of medicines was not currently available for the emergency department. It was not possible to undertake an audit for learning and improvement with the current available systems and processes.

The allergy status of patients was not always recorded. This meant allergies were not always highlighted and there was a potential for a medicine error. We saw on the 7 December 2023, a patient in the 'fit to sit' area was given two different antibiotics intravenously without having a wristband on or allergy status documented.

Staff did not always store or manage medicines safely or securely. Medicines storage areas seen were locked and secure with access only to authorised staff. However, medicines were not always managed and stored safely which was mainly due to some disorganised storage arrangements. In the 'clean utility' medicine storeroom we observed loose strips of medicines not in their original containers, with no coordinated system to easily locate a medicine. In the same-day emergency care area we found some out-of-date medicines had not been disposed of safely. These issues were also identified in medicines storage audits. There was a lack of individual staff responsibility to ensure medicines were stored following trust policy. This increased the potential risk of a medicine error, or a medicine not being located.

Resuscitation medicines required in an emergency were stored in tamper-evident boxes which followed Resuscitation Council UK guidance. Staff recorded safety checks on emergency medicines and equipment to ensure they were safe to use if needed in an emergency, but they did not pick up the requirement for them to be tamper-evident.

Controlled drugs (CD) were stored safely and securely with access restricted to authorised staff. As required, checks were undertaken and recorded by two staff twice a day. Checks of CDs showed they were within date and stock balances were accurate. The staff completed CD audits monthly. The November 2023 audit showed an increase in CD administration and recording compliance from 67% in the resuscitation area to 82% and an increase in compliance from 76% in September 2023 to 83% in October 2023 at the nurse's station.

The staff completed a safe and secure handling of medicines audit. Results from the 12 December 2023 audit showed 83% compliance. For each area of non-compliance there was an action to make improvements.

Staff did not always follow national practice to check patients had the correct medicines. There was a lack of a clear system to check and record what medicines patients were prescribed at home or by their GP. For example, the 'drug history' section on the electronic system was not completed in 11 out of 14 records reviewed.

Urgent and emergency services

Staff learned from medicine safety alerts and incidents to improve practice. The trust had an electronic system for recording incidents and staff we spoke to were able to identify its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported.

The trust had a Medicines Safety Officer in line with NHS England directives. They investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents.

The service commenced an audit of the patient notes following the inspection. They looked at 8 sets of notes and found 2 out of 8 patients did not receive their medicines within 60 minutes of it being prescribed. However, there was no action plan provided to us for assurance of learning and improvement associated with the audit.

Incidents

Managers investigated incidents but they did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, staff recognised and reported incidents and near misses and reported them appropriately.

There was no formal learning from incidents that happened in the department which meant staff could miss out on key learning and improvements required from incidents. Staff we asked were not able to tell us about any changes which had been made in the department following an incident. We were told learning from incidents was given at the safety huddles which were at the beginning and end of each shift and general learning was shared in an encrypted social messaging group. However, there was no mechanism for informing staff who did not attend the huddle or use the messaging group, so it was not clear all staff were included, updated or involved.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff received feedback from investigations of incidents they had recorded but did not always receive feedback from incidents from the department. Doctors told us they had huddles 3 times a day and incidents were occasionally discussed during these. Although 4 junior doctors we spoke to could not recall any discussions around serious incidents in the department.

Managers did not always share learning with their staff about incidents that had happened elsewhere. Staff told us they had ‘Feedback Friday’ and ‘Wisdom Wednesday’ newsletters where learning was shared from events that happened within the medicine directorate. We looked at three examples of Feedback Friday and Wisdom Wednesday newsletters and found there were no incidents or learning shared on these. We did not see any examples of incident feedback to staff within the department. Staff did not meet to discuss the feedback and look at improvements to patient care. Team meetings did not occur regularly, and staff were not able to tell us about improvements that had been made following incidents that had occurred. However, the trust had a patient safety panel every Friday where incidents were discussed that had occurred in the trust that week. The sisters attended this meeting for learning but there was no evidence of this being shared with the department.

The service had no ‘never events’ in the department in 2023. Never events are serious incidents or near misses which should not happen if safety systems and processes are followed. The most common incident categories were implementation of care and ongoing monitoring; access, admission, transfer, discharge; and medicine incidents.

Not all available information was shared with staff. A monthly matron’s ‘exception report’ was produced about important data and events, but key information from this was not disseminated to staff. This meant the department were not assured there was always learning from incidents and changes made to improve practice. The reports detailed

the incidents over the month and looked at the top themes. We looked at October and November 2023 exception reports (where they reported on the previous month's data). They showed there had been an increase in incidents with harm. These had increased from 18 in September 2023 to 22 in October 2023; five of these were moderate harm. All moderate harm incidents were reviewed by the division and a rapid review was completed where needed. However, with staffing pressures, there was a high number of incidents still to review, although this was reducing. Although learning was not evident following incidents, managers debriefed and supported staff after any serious incident. They did a 'hot' debrief immediately after an incident and then had a 'cold' debrief one to two weeks later. This gave the staff time to process how they felt about the incident.

There was a lack of assurance that learning was disseminated or embedded from serious incidents. We looked at 2 serious incident (SI) reviews from January and February 2023. These were detailed and comprehensive. One of the SIs was a cluster of incidents relating to patient's suffering pressure damage to their skin. It was found in the incident review that risk assessments were not completed in a timely manner, there was inadequate documentation of pressure damage and failure to use effective pressure relieving equipment. We looked at 8 sets of notes specifically looking at whether the pressure damage risk assessments (Anderson Tool) had been completed. Despite the serious incident findings, we found risk assessments had not been completed in 5 out of 8 sets of notes and pressure relieving equipment was not in use when indicated.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed two serious incidents and saw duty of candour had been undertaken and letters sent to all patients and families involved.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. However, actions were not always implemented from clinical audits to improve patient outcomes or care and treatment.

Guidelines and pathways were not always up to date or referencing national guidance. We saw that the guidelines and pathways for illnesses, such as diabetic ketoacidosis and sepsis, were available on the trust's intranet, however a few of them were out of date or lacked referencing from national guidelines. For example, we looked at the guideline for chronic obstructive pulmonary disease which had no references and was out of date. We also looked at the sepsis policy which had no author, no date, and no references to Sepsis UK. The reference used was 'Kidney Injury, April 2016' which was not an appropriate reference for a sepsis guideline.

The service used some of the National Institute for Health and Care Excellence (NICE) guidelines to ensure care was evidence-based but not all care was evidence-based and provided in line with guidance. For example, the service used up to date NICE support tools such as selecting people under 16 for a computerised tomography (CT) head scan (NG232) (2023) but it did not follow NICE NG51 sepsis guidelines.

The managers did not always action results found from clinical audits and make changes needed to improve care for patients. While the service participated in clinical audits which enabled them to show care was being provided in line with national recommendations and best practice, they did not always create action plans and put the actions into place. For example, the service completed a sepsis audit in April 2023 and found they did not always follow sepsis screening guidelines. We did not see any actions implemented from this sepsis audit and the service had not re-audited to check compliance. We saw that sepsis screening guidelines were still not followed. The sepsis 6 pathway was not used effectively and in all the records we checked for patients being treated with sepsis, they did not receive their antibiotic treatment within the 1-hour nationally recommended timeslot.

In accordance with national guidance, the department had a stroke pathway that ensured patients were seen promptly and there were good outcomes. The service provided rapid clinical assessment and CT scans with the option of an air ambulance transfer for the patient if they required thrombectomy at another specialist site. Stroke staff used a trust-approved application on their mobile phones to view the CT scans which enabled rapid responses. This meant the team could see and diagnose the scans promptly and treatment was able to be given. The stroke specialist nurse told us significant investment and research had been given to develop stroke care within the emergency department with good results. Outcomes of patients who had a stroke were collected and were mostly above national average. The sentinel stroke national audit programme showed a compliance of 97.6% for the trust which was higher than the national average of 93.2%. Data showed 100% of patients had a full stroke screening on arrival to the hospital; this was higher than the national average of 94.4%.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health.

Staff did not always make sure patients had enough to eat and drink. The service were delivered a selection of sandwiches in the kitchen, but if there was an influx of patients, these could run out. We did not see patients were always offered drinks regularly. When looking at the patient notes, it was not always clear when drinks or food had been offered. We looked at four sets of notes on our second visit and found three out of the four patients had been offered either one or two drinks; they had all been in the department over 14 hours. While some patients told us they were offered regular drinks, we spoke to a number of patients who had been in the department for more than 4 hours and they told us they had not been offered any food or drink, some of these had stayed overnight.

There were no drinks or food facilities in the waiting area. These were found within the SDEC corridor and just outside the waiting room. Not all patients knew these were there and we found patients or those supporting them could be waiting for 8 hours without a drink. Following the inspection, 2 extra staff members were placed in the waiting room and on our second visit, we saw drinks were being offered.

There was hot food available for patients at 12pm and 5pm. Healthcare assistants did a breakfast round which offered cereal and toast to patients who had stayed overnight.

Staff did not fully and accurately complete patients' fluid and nutrition charts where these were clinically indicated. We saw patients who were receiving fluid through a drip, patients who had been catheterised and a patient with acute kidney injury who did not have a fluid balance chart. On our second visit, staff had started using fluid balance charts for patients where clinically indicated. We were told training sessions were being provided to staff around the use of fluid balance charts and their importance.

Urgent and emergency services

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and did not always give pain relief in a timely way.

Staff assessed patients' pain using a recognised tool but did not always do this regularly or give pain relief in line with individual needs and evidence-based practice. Patients pain was routinely asked as part of the national early warning score assessment, but this was not completed regularly for all patients. Observations were not recorded regularly for most patients in the records we checked. Staff did not always check pain and giving pain relief was inconsistent. We looked at 12 sets of notes and we saw examples of when pain was assessed, and pain relief given. However, it was not clear from the notes whether patients' pain was regularly checked, and staff did not always check the effectiveness of analgesia.

Patients did not always receive pain relief soon after it was identified they needed it or requested it. On 7 December 2023, two patients within the pitstop area told us they had been waiting for over an hour for pain relief. We asked the nurse who was looking after them why they had not received it and they told us they had not had time to give it to them. Another patient told us they had to repeatedly ask for pain relief from different staff and it took a while to get any.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They created actions from the findings to make improvements. However, due to low consultant numbers, they did not always have time to make the improvements needed.

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. Outcomes for patients were mixed. Some were positive, consistent, and met expectations, such as national standards but some fell below national standards.

Staff completed the Royal College of Emergency Medicine audits on an annual basis, made actions to improve compliance, but did not always make sure they were completed. The audits included 'Consultant Sign off", 'Infection Prevention and Control (IPC)' and 'Pain in Children'. The consultant sign-off audit from 2022 showed 30% of patients had a consultant sign-off; this had since improved to 60% in 2023. The percentage of high-risk patients in 2022 who had consultant sign-off prior to discharge was 6.3%; this was worse than the national average of 35%. The audit showed 100% of consultants and senior specialists completed their own documentation following a patient review. There was no data available that showed consultant sign off for unplanned readmissions within 72 hours in children under 18 years of age and fever in babies under the age of 1 for 2022. However, 2023 data showed only 15% of these patients were documented to be seen or discussed with a consultant. The service was implementing key actions including further education to improve documentation compliance and allocating consultants in ED two administration hours on each shift to complete documentation and improve compliance. These results were discussed with the medical staff in July 2023.

There was good compliance with IPC screening, but not with the resultant actions taken to protect patients and others. The IPC audit showed good compliance with screening patients for infectious diseases, COVID-19 and vulnerable conditions on arrival; the department was better than the national average for all these metrics. This was a considerable improvement from the previous audit. However, they were worse than the national average where only 10% of patients where they had identified vulnerability were isolated in a side room and 75% of patients identified as potentially infectious being in an appropriate area; the national results for these were 24% and 80% respectively. There was an associated action plan which included education and improving the use of infection control checklists.

Improvements needed from audit findings were not always acted upon including acting on pain relief for children. We were told that due to the low number of consultants within the department, they did not always have time to put findings into practice and focus on quality improvement. The pain in children audit showed they were significantly higher (68%) than national average (38%) for administration of analgesia to children in moderate pain within 30 minutes of arrival and for re-evaluation of their pain following a dose of analgesia. However, only 31% of children had their pain assessed on arrival or at triage, this was lower than the national average of 54%. The audit showed only 28% of children in severe pain had analgesia administered within 30 minutes of arrival whereas the national performance was 58%. There was an action plan which included review of triage to ensure pain was identified early and education around pain assessment tools. These were due for completion in October 2023 and the audit had not been updated to show if these had been completed.

There was a lack of meaningful audit around patient outcomes. Managers were not fully sighted on issues within the department such as lack of completion of regular observations, lack of sepsis 6 compliance and delays in medicine administration as documentation audits were not completed. Where audits were completed, action plans were not always completed, and staff were not aware of the audit results. This meant changes were not always made as staff were not aware of the lack of compliance. Audit results were discussed by the managers within governance meetings, but these were not fed back to staff in the department. Staff told us they did not hear about any audit results apart from the most recent infection prevention and control audits as there had been a big focus on improving compliance.

There was evidence patients had good treatment on their first visit and most did not require a revisit to the department. Evidence showed the service had a lower than expected risk of re-attendance or similar to the England average from January to July 2023; the reattendance rate had fluctuated between 7% and 9%.

Competent staff

The service did not always make sure staff were fully competent for their roles. Staff performance review (appraisal) rates were low which meant staff were not always supported to develop.

There was a lot of demand on senior nursing staff to support a relatively junior workforce in nursing. Staff told us there was a high number of junior nursing staff who required support from the nurse in charge and often there were quite a few on shift at once which could be a challenge. Junior staff were working through their competencies and training but required support for some of these throughout their shifts. However, the department was fully established with band 6 and 7 roles and these staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

There was a gap in competency in emergency response for staff looking after children. As we have reported above, not all staff looking after children overnight had completed the required training to recognise or safeguard a deteriorating child.

Managers gave all new staff a full induction tailored to their role before they started work. This was comprehensive and ensured staff had specific training relative to the department prior to starting. New starters had an inhouse preceptorship programme for 12 months. The clinical practice development nurse (PDN) supported the learning and development needs of staff. They ensured training was completed and booked, and new starters were given extra support if needed.

There were a high number of new recruits to support, and this was a risk to overall staff competency. There were 17 new staff members in the nursing team which meant the PDN was struggling to ensure they were trained and provide the

support needed. This risked the department having a fall in overall staff competency. We were told the PDN, and education team found it hard to deliver all the training required to ensure competency for all the nurses in the department. Following the inspection, the managers recognised the training needs were high and compliance was not achievable with 1 PDN. Therefore, they were advertising for a second PDN for the department.

There was good support to new staff from their peers. There was a buddy team which had been set up which had 8 members of staff ranging from band 2 to band 6 who supported the new starters. This was set up by a band 6 international nurse who wanted to ensure there was a good support system particularly for the international nurses.

High pressures in the department meant that training and competencies were not being completed in a timely manner. All staff were assigned a team which was led by a band 6 nurse. They were responsible for identifying any training needs their staff had and giving them the time and opportunity to develop their skills and knowledge. However, we were told this did not always happen and the band 6s were not always able to support their teams with their development.

There was good quality training where time permitted. The service used the Royal College of Nursing competency booklets for emergency nursing. These were very comprehensive and covered all aspects of nursing within the department. The training for this was provided by the education team. The training team also ran a programme of skills to ensure the nurses remained up-to-date such as venepuncture, cannulation, and electrocardiogram training.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. In 2023, 53.5% of staff had received an appraisal. This was much lower than the trust target of 90%. During our second visit, the managers told us they had assigned a band 7 nurse to each band 6-led team to try to drive improvement with appraisal compliance. They aimed to improve by 20% by March 2024. The practice development nurse had developed a QR code for the staff to scan which took them directly to their self-reflection form which was required to be completed prior to the appraisal. This made it more accessible for staff to complete. When appraisals did take place, staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

There were link nurses within the department who assisting with training and educating the staff in certain areas such as blood transfusion, tissue viability, medicines and mental health where time constraints allowed.

There were low numbers of substantive consultants in the department which meant trainee doctors took priority for supervision over doctors without training posts. Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors told us the consultants and senior doctors were supportive and offered supervision where needed. We were told they were given regular teaching sessions which were well attended. As part of the national programme of revalidation, consultant appraisal rate was 100%.

There was no paediatric trained consultant within the emergency department. The Royal College of Paediatric and Child Health requires each emergency department treating children to have one paediatric emergency medicine (PEM) consultant. The senior leadership had not recognised the requirement for a PEM consultant and considered the department below the threshold due to the number of children seen. However, this was no longer a mitigating factor. There was a recruitment consultant advert live at the time of the inspection which was generic for both a PEM consultant and standard emergency medicine consultants. This included paediatric training within the job specification to provide improved paediatric competency, but this was not driving recruitment for a specific PEM consultant. The team were otherwise supported by the paediatric unit doctors and a senior paediatric doctor on call 24 hours 7 days a week.

Urgent and emergency services

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The doctors had a patient review huddle three times a day throughout their shifts. This meant the consultant had an overview of the patients within the department and the care that was required. We observed a huddle, and the consultant was providing the junior doctors with advice regarding the pathway required for the patient.

Managers actively worked together throughout the hospital to improve the flow through the hospital and ease the pressure in the emergency department. The service worked well with the patient flow team and bed management team. However, bed occupancy at the hospital was high. The patient flow coordinator worked with ward staff to identify beds and help move patients from the emergency department and onto a ward. The hospital managers held bed meetings four times a day where they reviewed number of patients, performance against the 4-hour standard, staffing and bed availability. This resulted in plans being drawn up for individual patients. We saw during the meetings plans were made to improve the flow in the hospital. For example, on 7 December, the decision was made to increase the number of patients 'boarding' on the wards from 17 to 25. Boarding is bringing a patient to a non-standard bed space on the ward for a temporary period when it is safe to do that for the patient. This was to ease the pressure within the ED as there were 20 patients who were waiting for a bed.

We were told that doctors, nurses, porters, cleaners, healthcare assistants and any other support staff all had good communication, a good rapport and worked well together.

The emergency nurse practitioners told us they worked well with the whole department. They were able to refer patients to services easily. For example, they had a patient who had fallen and needed assistance at home. They referred them to the frailty same-day emergency care team who arranged any social needs or admission if required. They said the frailty service enabled them to see more patients.

Specialty services supported the ED but more needed to be done to help with patient flow. The managers had produced, currently in draft, an ED internal professional standards document. This was to determine a standard required to enable ED to undertake relevant tests, treat the patient and request for a bed for the patient. However, there were concerns from the medical staff in the ED about support to them from speciality teams. The internal professional standards document required specialities to review their patients in ED within 30 minutes of receiving the referral. Data showed in the first two weeks of December, the psychiatric team took the longest to review their patients with an average time of 4 hours and 2 minutes; they saw 63 patients within these two weeks. The medical team saw the highest number of patients with 1,022 reviews; the average time to outcome was 2 hours 36 minutes which was similar to the orthopaedic teams. We spoke with the chief medical officer who told us work had been started with medical teams across the trust to find solutions and improved working practices to prioritise patients needing a consultation in the emergency department to help with the flow and the wellbeing of patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The team worked closely with the mental health liaison team to ensure these patients had specialist input where required.

Seven-day services

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

Urgent and emergency services

The emergency department was open 24 hours a day, every day, all year round. Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, 7 days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. If patients had full capacity, staff gained consent from patients for their care and treatment in line with legislation and guidance and where it was possible to obtain.

Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a mental health liaison team who advised on mental health issues. They were on site from 8am to 10pm and off site but on-call overnight. The staff reported they were very supportive. They also would see children aged 16-18 years old who had been seen by a clinician.

We saw that 75.8% of staff had completed their training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was lower than the trust target of 85%.

Staff we spoke with did not have good knowledge of the Mental Health Act. This meant if someone had been detained under the Mental Health Act, there was a risk staff would not fully understand how to protect their rights. Patients who lacked capacity to fully engage in treatment decisions and patients who had thoughts of self-harming and or ending their life were given 1 to 1 support where possible. We saw evidence that staff could get an agency mental health nurse to support with enhanced observations.

The mental health liaison team reviewed the patients and supported staff with the care. We looked at a set of records for a patient who was in the department with mental health concerns. There was a completed risk assessment and a referral to the mental health team who had assessed the patient promptly. They had put a detailed plan of support in place for discharge into the community through the crisis team. The staff told us the mental health team were supportive and prompt with their assessments. There was a monthly meeting with the mental health team, consultant, and ED sisters where they discussed support pathways, triage and frequent attenders.

The staff worked well together. There was a policy for restrictive intervention and restraint where security and porters were asked to support until the patient had calmed down. Some security and porters had received mental health first aid training and felt confident to assist the department where needed. One porter had received star of the month for supporting a mental health patient.

There was a pathway to follow for paediatric patients who presented in the department with mental health conditions and a child and young person's mental health assessment matrix which was completed. This enabled staff to ensure the patient was getting the right level of care required.

Is the service caring?

Good 

Urgent and emergency services

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

Compassionate care

Staff treated patients with compassion and kindness. However, due to the crowding in the department and the difficult environment there were some concerns around patient's privacy being met at all times. This was recognised by staff who were doing as much as was practicably possible to support privacy and dignity for patients.

We found staff were kind and trying their best to provide good care. Staff were mostly discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. However, the department was often crowded which meant staff were struggling to care well for their patients and always meet their needs.

We saw some excellent examples of good care and had some comments from patients including "staff were terrific and kept me up-to-date", "staff really helpful and the queue of patients is not their fault" and "wonderful, amazing staff". However, patients within 'fit to sit' had some examinations behind screens which did not always maintain their dignity. There was not enough space for all of the patients attending, and they were not always cared for in the most appropriate area. Some patients were held on a corridor with moveable screens to provide dignity when being examined. However, these screens had gaps in them and did not fully shield the patient.

Sometimes, patient information was hard to keep confidential in conversations. Due to the layout of the department and significant limitations with space, patients' private information could sometimes be overheard in a number of areas. Limitations in space made this largely unavoidable, but staff commented how they found it uncomfortable. Staff and also some patients were also wearing face masks, and this made communication more difficult and there was often the need to raise voices. The pitstop area was small and cramped and was a thoroughfare at times. Ambulance handovers were taken in the pitstop area in cramped conditions and information was able to be overheard by patients waiting. This too was largely unavoidable due to the limited space.

Managers recognised that lack of privacy was an issue. In response, they had converted a 'mini laboratory' into a new space to support clinical conversations. Staff told us they moved patients into a cubicle or the new space if a procedure needed performing or a private conversation, but this was not always possible due to the high volume of patients being seen.

The department had created a space to try to improve privacy for patients and ringfenced 2 assessment cubicles within majors. We saw these in constant use while we were there for assessing and examining patients. Managers acted upon the results of the urgent and emergency care survey in 2022. One of their lowest scores was for privacy when being examined. This was 7.9 out of 10 which was lower than the national average of 8.8.

Within the paediatric area, if staff needed further support with children and keeping them entertained, they contacted the hospital's play specialists from the ward who came to assist.

Emotional support

Staff mostly provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs and worked hard to meet them as much as possible.

Urgent and emergency services

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw the staff interact kindly with patients throughout the department including while they were being cared for in less suitable areas of the department.

We had mostly positive feedback from patients who recognised the difficult environment staff were working within. Some patients told us communication could be poor at times when they were not sure what was happening, and others told us staff had "gone out of their way to help" and they felt listened to.

The nurses were very supportive within the paediatric area. They told us they supported families after discharge. They gave an example of a patient who was struggling with their mental health following a family death and they had referred them to an agency to help with their bereavement.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. The CQC urgent and emergency care (UEC) survey 2022 report showed the trust scored 8.2 out of 10 for being listened to. The patients mostly felt the health professionals listened to what they had to say. Patients we spoke to generally felt listened to by the team.

Staff talked to patients in a way they could understand, using communication aids where necessary. There were interpreting services available when required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Where necessary staff supported patients to make informed decisions about their care. We observed staff explaining to patients, carers and relatives the choices they had, and they were given time to think and reflect. When we spoke to them, most patients were aware of the options available to them, to help make decisions.

Patient feedback was passed onto the staff either in the safety huddles or in newsletters. We saw in the October 2023 'shoutout newsletter' a patient had written "A&E team deserve a medal. Our daughter was seen within 5 minutes of checking in by a consultant, who was so kind and efficient." and "the nurses who dealt with me did so swiftly, with professionalism and care. I was sorted within two and a half hours" and "really impressed, everyone was so friendly, efficient, caring and attentive even though they were working under constant pressure for hours on end."

The feedback from the CQC UEC survey 2022 was average. They scored "about the same" as other trusts in England for all 9 sections of the survey. They scored worse for the questions regarding involving family, friend or carers and them having enough opportunity to talk. However positive comments included "the staff were attentive and caring but were stretched by the number of patients attending", "I was treated with a kind and gentle way by everyone who helped me that day" and "we were very impressed by the dedication and hard work of staff working in difficult conditions, overcrowding etc."

Is the service responsive?

Requires Improvement 

Urgent and emergency services

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

Service delivery to meet the needs of local people.

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

Although there had been improvements with the creation of additional services, managers were not able to provide services to meet the needs and rising demand of the local population. Services had evolved, patient numbers had increased, but the service did not always meet demand. This resulted in patients waiting for long periods of time to be seen in the department and to be moved out of the department into a hospital ward. The waiting area was often crowded along with all other areas of the department. The patient's waiting area was small for the number of patients attending and not all areas could be seen by the receptionists such as the minor's corridor. There was an appropriate waiting area for children.

However, senior manager analysed capacity and demand daily. They recognised the risks and capacity concerns were high on the risk register. However, mitigations were only making limited inroads to improve flow and improve the waiting times for patients in the department. The increased demand meant the staff were not always able to ensure all patients were safe and well cared for. Due to the lack of time, staff resources and some poor record systems, patients were not having their observations completed regularly, medicines were delayed, and risks were not always assessed in a timely manner.

Not all facilities and premises were appropriate for the service being delivered. There were not enough cubicles in majors to care for the number of patients in the department. This meant patients were cared for in the corridors on trolleys and within the waiting room. Patients spent long periods of times, often more than 12 hours, in recliner chairs and on trolleys.

There was a service to divert less urgent patients to a nurse-led service. The service had a minor injuries department staffed by emergency nurse practitioners from 8am to 9.30pm daily and saw 15 to 20% of patients who attended the department.

The same-day emergency care department (SDEC) was seeing a high volume of patients compared nationally. Although it was helping with capacity constraints for the emergency department, the unit was often full and did not have enough space to take all patients who could have been diverted there throughout the day. Patients who were seen in the SDEC were discharged the same-day and if they needed further treatment, they were often brought back the next day into SDEC. This helped to relieve the pressure within the emergency department. However, staff told us SDEC was often too busy treating patients brought back in from the previous day that there was not enough space to take new patients from that day. The lack of availability of capacity in SDEC was on the department's risk register. However, over the last year, the SDEC was responsive to patients and saw a high volume. The activity rate had been above both the regional and England average. In September 2023, the SDEC rate for Hereford County Hospital was 44.8% compared to the England mean of 37.9%. This placed Hereford County Hospital in the top 25% of trusts in England.

The service had a 'virtual ward' which was run by advanced nurse practitioners. This is where care was provided at home to alleviate the pressures on hospitals. The role of the virtual ward was admission avoidance. There were 15 beds under acute medicine and five under the frailty speciality. The hospital at home team saw these patients and monitored them. They reviewed the patient list in the emergency department and selected appropriate patients for this service.

The service did not always have suitable facilities to meet the needs of patients' families. Due to the lack of space in the department, relatives or visitors were often standing around as there was not enough seating for them. However, there was a relative's room within the department for private conversations if required.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports so they had all the right and most important information about the patients. We saw there were sensory boxes available. These included fidget toys, noise cancelling headphones and fiddle toys for people with high levels of anxiety or cognitive impairment. There was a notice in the waiting room telling patients of the availability of sensory boxes and what was available to support people who were neurodiverse. For example, there was a quiet space in the paediatric waiting area.

Dementia training was provided by the trust within the mandatory training; 84% of nursing staff had completed this.

The reception desk had a lower section for patients who were in a wheelchair to communicate effectively and there was equipment available for patients who had hearing impairment.

The trust had improved their frailty service for patients. There was a dedicated frailty team and area within the same-day emergency care unit. There were 6 beds for overnight care where needed as well as 4 chairs. It had strict criteria to accept patients. Staff reviewed and selected the most appropriate patients to stay overnight and avoid admission to the wards with a view of then being discharged home. They also admitted patients from ambulances; we saw three patients on the 6 December 2023 who were admitted directly from ambulances. This reduced the pressure within the emergency department.

There was limited written information in other formats. The service had information leaflets available, but they were only available in English. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Receptionists told us patients often used their phones to translate which was quicker.

The crowding in the department made it difficult to provide areas for some patient's cultural or personal needs. Some areas of the department provided mixed sex accommodation overnight such as the 'fit to sit' area. This was permitted and within national guidance on mixed sex rules in emergency care, but it was difficult for staff to always respect the individual personal, cultural, social and religious needs of each patient cared for in these areas.

Staff had access to communication aids to help patients become partners in their care and treatment. There were some pictorial guides so people with hearing, learning or speaking difficulties which could help communicate basic needs, such as for pain relief.

We spoke to a patient who had Down's syndrome and their carers who were accompanying them. The patient was happy with the care and where they were situated within the department. The carers told us the provisions for patients with learning disabilities (LD) were good. There were two LD liaison nurses who they had called in advance to arriving who

were described as 'fantastic'. They were going to come and see the patient while they were in the department and had previously attended a 'best interest' meeting with them. We were told if carers or the patient did not pre-phone prior to their arrival, the staff arranged it, and they were seen by the LD team most of the time. However, they said on this visit no staff had looked at the patients LD 'This is me' passport despite it being highlighted to them.

There was support for children with a learning disability. There was a specialist learning disability paediatric nurse on the ward who would support the paediatric department if required. The paediatric team had support from the child and adolescent mental health service for complex discharges.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They escalated the need to extra support to the matron and offered 1 to 1 care. However, there was no appropriate area for patients who had learning difficulties and who might have displayed challenging behaviour. Funding had been requested to provide a suitable area.

Access and flow

People could usually access the service when they needed it. However, this was not always promptly as waiting times and arrangements to admit, treat and discharge patients were not meeting national standards. However, there had been a concerted effort to reduce ambulance handover delays. The department recognised the risk to the community of ambulances being held up to handover patients.

Managers monitored waiting times but were unable to make sure patients could access emergency services when needed and receive their treatment within agreed timeframes and national standards. When we visited at 8pm on 5 December 2023, there were 67 patients in the department with the longest patient waiting 10 hours 44 minutes and 26 patients had been waiting over 4 hours. The waiting times increased over the few days we were in the department. On 7 December 2023, at 11am there was a patient who had been there for 26 hours, there were 42 patients in the department and over 20 patients waiting for beds.

Managers were aware of capacity issues and created solutions to try to increase the flow through the department. However, due to the number of people using the service, and capacity issues within the rest of the hospital, there were long delays in accessing assessment, treatment and admission or discharge, and national standards for ED care were not met. Many staff told us, and we saw it ourselves, the department was crowded, and some patients experienced long waits which resulted in not meeting everyone's privacy and dignity at all times and potential additional clinical risk. There were some systems to manage the flow of patients through the ED and to discharge or to admit patients to the hospital when capacity was critical. The main solution included 'boarding' patients on the wards and increasing this number to provide more beds. Boarding is bringing a patient to a non-standard bed space on the ward for a temporary period when it is safe to do that for the patient. The trust had implemented a flow model in October 2022 where they 'boarded' patients on the ward. This was happening daily. While we were there, the hospital increased the capacity of patients being boarded from 17 up to 25 patients across the wards to improve the flow in the ED.

Senior managers constantly addressed the capacity in the department, but with limited options for success due to pressures throughout the health and care system. They could view the length of time each patient had been in the department, and what they were waiting for, including speciality reviews or bed admissions. The computer dashboard displayed the number of patients arriving from ambulances and who walked in. The data was discussed at bed meetings four times a day, or more if there were increased operational pressures. These meetings were well run and discussed relevant issues, such as demand, capacity within the hospital, as well as the level and safety of staffing. During our inspection, the safety status of the department was categorised as "severe pressure". All senior staff identified flow through the department as the most significant challenge. Due to capacity and flow issues, the staff were looking after

patients from the previous day due to the lack of beds, while also reviewing and treating 200 plus new patients per day. Capacity and flow issues were escalated to the site team. However, the team were struggling due to the lack of flow. For example, on 7 December 2023, we observed within the 11am safety huddle, the team discussed that the hospital was short of 50 beds for patients waiting for care and treatment.

Patients often did not always receive treatment within agreed timeframes and national standards. The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival seeing a decision-making clinician should be less than 1 hour. In 2023, the median time to treatment had consistently increased to above the England average from 49 minutes in January 2023 to 72 minutes in July 2023.

Along with all EDs in England for around seven years, the department consistently failed to meet the 4-hour waiting standard. There was some improvement in meeting the 4-hour standard over a 12-month period; the percentage was 44.3% in December 2022, and 52.9% in December 2023. In November 2023, 40% of patients waited over 4 hours for a clinical decision about their onward care. This was against the NHS constitutional standard that patients should wait no more than four hours for a decision about their onward care or discharge home.

With a concerted departmental effort, there was a relatively improved performance in patients being handed over from ambulances. The department recognised the risk to the community of ambulances being held waiting to handover patients. The department had seen the percentage of ambulance handovers taking over 60 minutes fluctuate above and below the England average (mostly below or better than). In October 2023, performance showed 81% of ambulances were offloaded in 30 minutes and 94% in less than an hour. From 4 to 10 December 2023 staff took an average of 32 minutes and 49 seconds to receive ambulance handovers. This was better than the regional average of 1 hour 9 minutes. During this time there had been a maximum wait for a handover of 3 hours 34 minutes. Data showed 83% of handovers took less than 1 hour and 73% took place in less than 30 minutes.

There were too many patients waiting for more than 12 hours on a trolley, but this had recently improved.

- Patients' median total time in ED was consistently longer than the England average.
- From March 2023 to July 2023, the England average length of stay decreased from 182 minutes to 170 minutes while at County Hospital, the average was 238 minutes.
- There was a decrease in the number of patients waiting more than 12 hours from the decision to admit to admission from 346 in December 2022, to 226 in December 2023; this was better than the Midlands average.

The service had improved its arrangements for transferring ambulance patients in which allowed ambulances to be freed up more quickly. The hospital was ranked 6 out of 20 hospitals in its region for its handover time for 4 to 10 December 2023 with an average handover time of 32 minutes 49 seconds. The pitstop area provided swift handover with ambulance staff and one we observed between the ambulance team and the pitstop team was efficient and effective.

The department had daily issues with finding beds for patients, we saw managers actively trying to resolve this and find solutions. There were five patients on the 6 December 2023 who were waiting cardiology beds with monitoring which were not available. One was moved out of resus and transferred to the major's area while awaiting a bed.

Following the inspection, senior staff informed us the trust had changed its pathway for patients who have suspected or known myocardial infarction who cannot be appropriately placed within the emergency department. The new pathway meant these patients would be transferred directly to the cardiology ward regardless of bed capacity so they could receive specialist management, monitoring, and oversight. They were also going to develop further exclusion criteria for the 'fit to sit' area to ensure appropriate escalation processes were used for higher risk patients.

Urgent and emergency services

More people than average left the department before being seen. This is indicative of patients being made to wait too long to be seen. The percentage of people who left the department before being seen for treatment was mostly above the Midlands and England averages. From January to July 2023 the percentage increased from 4.6% to 7.5%. Patients who chose to leave the department before assessment or treatment were given advice as to any risks that they were taking where possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them, but they did not always share lessons learned with all staff.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. The complaints were reviewed by the matron and general manager and allocated to staff based on theme. There was a consultant assigned to reviewing complaints and we were told they were very responsive. Managers told us they phoned patients to try to resolve the complaint informally.

However, managers did not always share feedback from complaints with staff for learning, improvement and development and the number received were increasing. Staff were not aware of complaint themes or changes that had been made following a complaint. We were told that feedback was given either within safety huddles or within an encrypted closed messaging application. There was a risk that staff would be miss these communications and be unaware of changes needed to improve. The service had a higher-than-average number of complaints compared to other areas in the trust. They had received 74 complaints in 2023. These had steadily been increasing from below 5 in May 2023, to 27 in October 2023. The main themes were waiting times, communication, length of stay in the department and mis-diagnosis.

The service clearly displayed information about how to raise a concern in patient areas. There were information boards around the department telling patients how they could make a complaint and how to get support from the Patient Advice and Liaison Service (PALS). We attended a meeting which was held weekly with the PALS team and a band 7 sister to discuss any recent concerns and plans to address them before they became formal complaints. They had received 18 concerns through PALS in November 2023. We observed a concern discussed in detail and a plan was made for dealing with it.

We saw there were limited actions from the complaints received in the department to make improvements. The governance team produced a monthly assurance report. This described the complaints received and looked at themes found. They were reviewed at governance meetings, but no actions taken to make improvements.

Staff knew how to acknowledge complaints and patients received feedback from the trust after the investigation into their complaint.

Is the service well-led?

Requires Improvement 

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

Urgent and emergency services

Leadership

Leaders had the skills and abilities to run the service. 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 leaders had the skills and abilities to run the service, although were struggling with the demands on everyone's time and priorities. The senior leadership team for emergency care was led by a team with the matron, ED clinical director, and ED general manager. They were supported by senior staff at a divisional level. The ED team had good levels of operational knowledge to lead the department in pressurised circumstances. There was an emergency care consultant who was responsible for clinical care in the department and another who was responsible for the governance. They worked alongside the leadership team to provide local leadership direct to the department. The senior leadership team met monthly to discuss quality in the department although they had adjoining offices and had informal discussions daily.

Leaders were supportive of their staff and caring about the service. There was a team of band 7 nurses who managed and ran the department and were managed by the matron. We were told they were approachable, always listened and gave regular feedback. The managers were visible in the department. There were two or three on each day with at least one of them assigned to work clinically; they did not work any night shifts. We saw a dedicated and professional team of staff across all grades. They all had respect for each other, and their roles and they were proud of their team. It was clear from all staff we spoke with that leaders were supportive of their staff and passionate about their service. They were aware of how the ED environment and pressures in the workplace affected the welfare of their staff. They supported the staff who worked hard and tried to ease the pressures of working in such a busy environment.

Senior staff in the department were fully aware of the challenges they faced and felt the full responsibility of delivering a safe service for all. The medical team and the nursing team worked well together and spoke highly of each other's abilities and support.

Staff development was encouraged. Nurses told us they were encouraged to apply for more senior roles within the department. This meant they were fully recruited in the senior roles such as band 6 and 7 and had vacant band 5 posts as these staff had progressed within the department.

Vision and Strategy

The service had objectives for what it wanted to achieve but they were not always achievable in the current pressures. Leaders were working on a strategy to turn the vision into action. The vision was focused on the sustainability of workforce as it supported safe patient care.

At the time of our inspection, the vision for the department was focused on improving the flow of patients through the hospital but due to capacity pressures there was limited progress. The delay in discharging patients safely from ward beds meant there was still poor flow through the department which led to long delays for the patient's needing admission. The trust had a standard operating procedure (SOP) called "enabling proactive flow from ED" which included 'boarding' of patients to release the pressures within the ED. Boarding is bringing a patient to a non-standard bed space on the ward for a temporary period when it is safe to do that for the patient. The aim of this SOP was to not have patients boarding on the wards out of hours. However, when pressures were high, this would inevitably happen, and we were told this currently happened every day. As well as failures to discharge due to pressures for care packages in the community, the pathways the hospital used to move patients promptly into community beds were failing due to a similar lack of bed capacity.

There was quality improvement plan, or vision, which had two key ambitions for 2023/24:

Urgent and emergency services

1. Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred, or discharged within 4 hours by March 2024, with further improvement in 2024/25.
2. Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

To achieve these objectives, the department had a number of initiatives and sustained improvements to enable improved patient safety including reduction in 'time to be seen' and time to treatment or discharge; demand and capacity planning for more appropriate staffing levels; improved patient safety through increased quality of care; and improved flow and reduced crowding through further development of alternatives to the emergency department.

A strategy was being produced to sit alongside the vision for the service. The main focus was to improve the numbers, skills and experience of the workforce. The senior leadership recognised the environment unlikely to significantly improve in the short or medium terms, and focusing on the workforce could have a bigger impact. The premise of the workforce plan was to ensure early, consistent senior decision making throughout the emergency care pathway. The plan and recommendations were based on national evidence, local analysis and were aligned to the strategic objectives of the organisation. It had been developed by the service and underpinned by a focus on early continuous assessment, rapid treatment, and discharge. Implementation of the proposed model would mean staff could deliver a comprehensive consultant led service 7 days a week in line with national guidelines.

Managers had identified issues within the demand and capacity due to a low workforce and not having adequate resources. They reviewed the nursing and medical workforces to identify the gaps. They looked at where the busy periods were, recommended an alternative shift pattern which would allow them to review the true demand and put a strategy to the executive team. They had recently put in a business case for an investment to create a more senior medical workforce. This included a further five consultants and eight middle grade doctors to be in line with the Royal College of Emergency Medicine requirements for senior staffing within the department. Based on the analysis they had completed, they felt the strategy to recruit more senior staff would meet the current demand for patients seen.

The trust had increased the capacity within the department by expanding same-day emergency care (SDEC) and adding a frailty SDEC service and later in December 2023, a surgical SDEC service. The department also had capacity within the virtual ward which, again, it wanted to expand further to increase capacity.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care but due to pressures and the capacity of the department, they were not always enabled to deliver high quality care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Nurses and doctors spoke highly of each other and worked well as a team. There was a good understanding between staff in different roles and the pressures they each faced; there was an inclusive culture. We observed staff working well together and communicating as a team.

Nursing staff said they knew who to approach if they had concerns and some told us they had raised issues with line managers or matrons in the past and had been supported and encouraged in this process. Staff told us they felt comfortable in reporting incidents, there was a no blame culture and they always received individual feedback.

Clinical leaders were visible in the department, and it was clear they were respected by their teams. We were told some senior staff worked clinically in the department to cover staff shortages and help teams deal with the workload. There were daily safety huddles where staff could raise issues.

Urgent and emergency services

Junior doctors spoke positively of their training experiences and said their consultants were very approachable.

There was a wellbeing nurse who visited the department regularly to offer support to staff and education around mental health and wellbeing.

One of the paediatric nurses won the 'going extra mile award' for assisting with an adult collapse in the waiting room. They were really pleased to have won this and felt part of the emergency department team.

However, the department was often overwhelmed with patients and there was not always enough staff to carry out all the required tasks in a timely manner. Some staff did not feel this was always recognised by all of the managers and they did not always step in to help when required. They felt upset that patients were in the department for hours.

Governance

Leaders did not operate effective governance processes. Audits were completed but actions were not always taken to make improvements. Staff at all levels were clear about their roles and accountabilities but they did not have regular opportunities to meet, discuss and learn from the performance of the service.

The governance processes were not effective. Audits were not used effectively to drive improvement and information was not shared with staff. There were systems to assess, monitor and improve the quality of care but these did not always ensure changes were made. The department had monthly governance meetings where they reviewed performance, incidents, complaints, and audits. Staff told us they were not aware of what was discussed in governance meetings and information was not shared to ensure improvements were made. For example, at the 14 November 2023 governance meeting, the team discussed issues regarding discharging patients with cannulas in and not being sent home with medicines following adverse incidents reported. They discussed how the discharge checklist was not being utilised properly. An action plan was drawn up to make improvements including a standard operating procedure and mandating this checklist on their electronic records. However, we were told by a number of staff that there were no discharge checklists and no actions to take had been fed back about patients being discharged with cannulas.

The groundwork for governance was undertaken, but the follow-up, identifiable improvements, re-audits and learning were not in evidence. The governance team produced an 'exception report' for the department which was presented monthly. It included incident data, the risk register, patient falls data, training and appraisal data for staff and audit results. We looked at October and November 2023 reports. The data was analysed for each of these areas but there was no clear action plan with an owner to ensure improvement was driven forward in areas where needed.

Managers were not aware of some of the issues we found while on inspection due to a lack of comprehensive governance, an effective audit programme, and learning from incidents. Some audits were completed to assess and monitor the quality of care. However, we did not see audits for documentation, NEWS2 compliance and medicines management. Patient observations and monitoring were not recorded regularly, the sepsis 6 bundle was not well used, fluid balance charts were not used for high-risk patients and time critical medicines and other medicines were not administered on time.

There was learning from incidents around poor observations and escalation of concerns which had not been learned from. In an incident involving a patient in 2023, the investigation found there was a lack of regular observations and abnormal observations were not escalated. We also found observations were not completed regularly in the notes we

looked at. Following the inspection, audits were implemented to improve compliance. We saw a documentation audit including NEWS2 completion and sepsis audit had been completed. However, the action plans associated were brief, did not contain an owner or completion date. Therefore, it was difficult to know whose responsibility it was to implement the changes and when and how they would be completed.

There were good quality audits, but with no outcomes. Some audits did not contain action plans so there was no evidence of actions made to improve compliance. For example, the matron completed an infection prevention assurance checklist and a matron's audit of the department bi-monthly. These looked at all areas of the department in depth including clinical practice, infection prevention, staff knowledge and safety of all areas. However, there was no associated action plan. We saw there were some of the same issues in the October 2023 audit as in the December 2023 audit and it was unclear if there were any actions to make improvements. Furthermore, the band 7 nurses completed a weekly assurance audit. We looked at four of these from November and December 2023. We found these were completed but mostly did not contain actions. We saw concerns about poor compliance with processes and records remained unchanged. For example, on the 27 November 2023 weekly assurance audit, the nurse highlighted that sharps bins were incorrectly assembled, old 'I am clean' stickers were on equipment and disinfectant sachets were stored in an unlocked cupboard, these same issues were found at the 4 December 2023 audit and neither had actions to rectify this.

The managers were not fully aware of all the risks in the department. For example, they did not ensure the nurses who covered the paediatric ED overnight had sufficient training in paediatric immediate life support, safeguarding children's level 3, and paediatric competencies; this was not on the department risk register. Following the inspection, the managers provided assurance that only competent trained staff were covering the department overnight.

Although the trust had implemented new pathways for patients, there was a lack of effective strategy for managing the poor flow within the department when it escalated and the outcomes for patients. The managers actively discussed the poor flow daily and moved patients through the department when possible. However, patients were consistently not receiving treatment within agreed timeframes and national standards and staying in the department for long periods of time. There was no clear short-term strategy for improving the flow for the patients and sustaining any improved flow.

There was no formal feedback for staff to learn and make improvements within the department. Full departmental team meetings or something equivalent for staff did not happen. The department had team meetings for admin staff, clinical managers and matron meetings for the band 7's and 6's. For example, we looked at minutes from the band 6 and 7 meeting in November 2023 where they discussed infection prevention and control measures, appraisals, and the role of the nurse in charge, However, there were no clear actions in the meeting for making improvements. They did not discuss training, incidents, complaints, feedback from governance meetings or audits. We did not see any minutes for team meetings for bands 2 to 5. Staff told us they had them occasionally but had not for a while. We were told they were unable to hold a full team meeting for all staff grades due to the nature of the service, but an alternative format which worked for staff had not been implemented.

Following our second visit, the matron created a draft governance newsletter to keep staff informed. It detailed the top risks, complaint themes, incident themes and new policies within the department. However, it did not go into detail and areas for improvement. This was due to be circulated in January 2024 once it was finalised and agreed. The matron had also implemented several new standard operating procedures. These included initial clinical assessment and use of the Manchester triage tool, care of patients in the waiting room, and identification and management of sepsis in patients over 18 years in the emergency department. On our second visit we could see this was making a positive difference for staff and patients.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and create actions to reduce their impact.

Although there was a process for identifying, recording, and managing risks, the leadership team were not aware of all the risks in the department or how to identify them. The service had a risk register which was monitored by the leadership team. It was also overseen at an executive level through the trust's board assurance framework. The risk register was discussed within the monthly risk review meeting. We looked at the minutes and action plan from 11 September 2023 meeting. We saw risks were added onto the risk register and action plan was updated to ensure the risks were escalated. However, it was clear managers were not aware of all the risks in the department. There were several risks we identified on inspection which were not on the risk register. These included:

- Poor environment including lack of visibility in the waiting room.
- .
- Computer systems which are not fit for purpose and lead to further risks for the patients.

The department risk register listed 18 risks. The highest risk was the risk of harm to patient due to long waits within the ED. We were told the most significant current risks in the department were shortage of staffing and skill mix and crowding for patients. However, these risks were not on the risk register. Staff we spoke with were not aware of the risks on the risk register including band 6 and 7 sisters. Following our inspection, the matron produced a governance newsletter which detailed the top risks in the department.

Risks remained for patients who were waiting a long time in the ED. It was not possible to mitigate all the risks associated with running the department at over capacity. Where there were high numbers of patients in the department it was difficult to have thorough oversight of every patient. Due to expansion to help overcapacity, and a department not designed for the space it now occupied, some areas of the waiting area and corridors had limited visibility. Risks existed for patients to deteriorate rapidly without being detected. These issues with safety and visibility of patients had not been recognised and were not on the risk register.

There was a lack of evidence of learning from avoidable deaths. Mortality and morbidity (M&M) meetings were scheduled to take place monthly but were mostly cancelled due to lack of consultant availability due to vacancies and operational pressures. We were told the ED governance lead held quarterly M&M meetings but there was no written evidence of these taking place. However, the governance team did review some patient deaths. The leadership team submitted an M&M review in February 2023 to the trust overarching M&M review which looked at 2 patients who died in the ED. The learning that was taken from the notes was that end of life booklets were not being completed and nursing staff were documenting on behalf of the medical team. However, they found expected deaths were acted upon in a timely manner and staff prioritised patient comfort and in-depth discussions with family were evident. There were no actions from this meeting. Following the inspection, the trust told us they were going to address the lack of M&M meetings. They had two new consultants starting in January and February 2024 and the trust told us M&M meetings were going to be held monthly and minuted.

Information Management

The service did not always collect reliable data. Staff were required to use several different information technology systems which were not efficient. Staff could not always find the data they needed to understand performance, make decisions and improvements. However, the information systems were secure, but some records were left open and unattended.

Data collection and record management in the department was not always reliable. Staff were required to use two different computer systems for the patients records and a third for medicines. This made it difficult to effectively audit patients' data and see the patient's clinical pathway through the department. Notes were then printed when the patient was moved to a ward within the hospital. The managers acknowledged the difficulties the trust's computer systems had and the impact they had on efficiency and understanding safety and quality care. There was a long-term strategy to move the ED computer system to the same one used by the rest of the hospital. However, the current timescale was 2025. There was no interim solution to improve the information management in the department and the risks for patients. This was fed back to the managers who told us they would audit the data and aim to improve and implement changes where necessary.

At times, some patients' electronic records were left unattended and not all staff had updated training in data security. There were three instances on our second visit where we saw patients' electronic records left open on unattended computer screens. These were in areas where they could be accessed by unauthorised people with a risk to them being tampered with or viewed. Not all staff had updated their training around information governance and data protection. Data showed 61% of medical staff and 65% of nursing staff had completed information governance and data security mandatory training. This was lower than the trust target of 85%.

Engagement

Leaders actively and openly engaged with staff to plan and manage services. However, there was limited feedback gathered to be able to engage with the views and experiences of patients.

Managers engaged with staff to gather their views on changes they wanted to make in the department. In May 2023, the leaders held an ED summit where over 80 members of staff attended. Staff completed an 'ideas' survey at the end of the summit to ensure managers captured all staff views. An action plan was created against issues which had arisen and for each area within the department. Actions included opening the reception areas further, so patients were more visible, nurse allocation to the waiting room and protected autism areas. While not all actions had been completed, there was clear documentation about how managers were wanting to make improvements within the department, and timescales to do so.

There were a number of newsletters within the department which kept staff informed and they could contribute to. They had 'Wisdom Wednesday', 'Feedback Friday' and 'Shoutout Newsletter' every few months. Wisdom Wednesday focused on different teaching themes, for example, March 2023 focus was stroke care and August 2023 was safeguarding children. Feedback Friday was more focused on updates. For example, November 2023 reminded staff about wearing masks in certain areas, building work that was happening and car parking. The Shoutout Newsletter gave information for the medical division including ED. They had a 'shout out' section where staff could praise other team members. For example, in October 2023 there was a comment which said, "Thank you for the ED team, you are all fantastic". They also had patient experiences which included good feedback from patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The patients were invited to complete a friends and family test. The response rate was low (18%) between 11 November and 11 December 2023. The service struggled to get a good response from patients which was not unlike other emergency departments. The results showed 71% of responses were positive and 19% were negative. There was otherwise limited engagement with patients to get feedback and no plans seen to improve the response rate to the friends and family test.

Urgent and emergency services

Learning, continuous improvement and innovation

All staff were committed to improving services, even though time and space was needed to make this work. Following feedback to the senior leadership team after our first visit on site, improvements were underway to address in earnest many of the concerns we raised.

The service had benchmarked its processes with another urgent care service within their foundation group. They were keen to make improvements for the patients and reduce the risks.

On our second visit, we saw the staff on all levels had engaged with the feedback given and made changes to make improvements and increase compliance in many areas. We found the staff responsive and keen to show us the improvements they had made following our first visit and were enthused by further improvements they planned to make.

Areas for improvement

Action the service must take to improve:

- The provider must ensure it is assessing the risks to the health and safety of patients of receiving care or treatment and doing all that is reasonably practicable to mitigate any such risks through carrying out and documenting regular observations, clinically-led navigation of patients through the department provided by trained and experienced staff, managing patients medicines on time, assessing and responding to deteriorating patients and responding to any risks such as sepsis, pressure ulcers, falls or patients in pain. (Regulation 12 (2) (a)(b): Safe care and treatment).
- The provider must ensure it has sufficient numbers of suitably qualified, competent, skilled and experienced staff who receive such appropriate training to carry out the duties they are employed to perform and ensure staff are trained to the right competency in safeguarding and life support. The provider must have sufficient medical staff to run the department safely and effectively including a paediatric emergency medicine consultant. (Regulation 18 (1) (2) (a): Staffing).
- The provider must ensure it is assessing the risks to the health and safety of patients of receiving care or treatment and doing all that is reasonably practicable to mitigate any such risks through effective and safe care to patients needing ongoing treatment but unable to have timely access to a hospital bed. (Regulation 12 (2) (a)(b): Safe care and treatment).
- The provider must ensure there are systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. It must assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity. The service must have an effective governance system, risk profile and audit programme to be assured it is providing safe quality care and knows and addresses where it should improve. (Regulation 17 (1) (2) (a)(b): Good governance).

Action the service should take to improve:

- The service should improve the safe and proper management of medicines are stored safely and appropriately. (Regulation 12).
- The service should ensure improved arrangements for offering food and drink to patients who have been waiting a long time to be seen, transferred or discharged.

Urgent and emergency services

- The service should consider how it uses patient identification, such as wristbands, to determine if this is working effectively.
- The service should consider improving the response when requesting patient feedback.
- The trust should ensure the privacy and dignity of all patients is maintained at all times.

Our inspection team

How we carried out the inspection

We inspected this service on 5, 6 and 7 December 2023 (first visit) and did a follow up inspection on the 20 December 2023 (second visit). The first visit was an unannounced full core service inspection looking at urgent and emergency care. We checked the quality of the services in response to emerging risks within the department. We visited all areas of the emergency department including the waiting rooms, resuscitation, minors, majors and same-day emergency care services.

The team that inspected the service comprised 4 CQC inspectors, a mental health inspector, a medicines inspector and 2 specialist advisors with expertise in emergency medicine. The inspection was overseen by an operational manager and deputy director.

During both visits we spoke with around 50 staff members including nursing staff, healthcare assistants, ambulance staff, cleaners, doctors and managers. We spoke to 35 patients and 9 relatives or carers, and we reviewed 16 patient records.

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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing