

The Pennine Acute Hospitals NHS Trust

The Royal Oldham Hospital

Inspection report

Rochdale Road
Oldham
OL1 2JH
Tel: 01616240420
www.pat.nhs.uk

Date of inspection visit: 30 November 2020
Date of publication: 10/02/2021

Ratings

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

Our findings

Overall summary of services at The Royal Oldham Hospital

Requires Improvement ● → ←

The Royal Oldham Hospital serves a population of approximately 230,000 people in the Oldham area. There are approximately 445 inpatient beds on the site. The hospital is part of the Pennine Acute Hospitals NHS Trust.

We carried out a focused inspection of The Royal Oldham Hospital's urgent and emergency care service on 30 November 2020 as part of our winter pressures programme. This was the only service we inspected during this inspection.

We took into account nationally available performance data and concerns we had received about the safety and quality of the services. We inspected against the safe, responsive and well-led key questions; we inspected key lines of enquiry relevant to the winter pressures programme.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Before the inspection, we reviewed information that we had requested from the trust about the intelligence we had received.

Following our inspection, we wrote to the trust under section 31 of the Health and Social Care Act 2008. This was because we were concerned about the potential significant risk of harm to patients. The trust took immediate action to address our concerns and developed an action plan to make and embed improvements to the service.

Our rating of the urgent and emergency care service went down. We rated it as requires improvement. The overall rating for the hospital stayed the same.

See the urgent and emergency care section for what we found.

How we carried out the inspection

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

Urgent and emergency services

Requires Improvement ● ↓

The emergency department at The Royal Oldham Hospital provides emergency care and treatment to adults and children 24 hours a day seven days a week. The department is the major trauma unit for the population of Oldham.

Since our last inspection, physical changes have been made to the department, to manage patients through the COVID-19 pandemic. This included it now having two 'majors' assessment and treatment areas.

Majors A was used for the management of patients attending with respiratory symptoms and with known or suspected COVID infection. It included four isolation cubicles where aerosol generating procedures (AGPs) could be undertaken and a further four cubicles. Patients waiting to be seen in majors A were directed to the 'respiratory' corridor.

Majors B was used for the management of patients attending with other, non-respiratory conditions or symptoms. Patients waiting to be seen in majors B were directed to the 'non-respiratory' corridor.

The paediatric emergency department had a separate waiting area and included five curtained cubicles and one side room to support the care of children with respiratory symptoms.

There was an urgent treatment service operating 24 hours a day. The service was led by the emergency department and supported by primary care services and GP services for 12 hours a day. The urgent treatment unit also hosted the emergency department nurse streaming service and the minor injuries service.

The department was attended by a total of 105,036 patients between 1 November 2019 and 30 November 2020. Of these, 28,508 patients were brought by ambulance. The department admitted 31,319 patients to the hospital for ongoing care and treatment.

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

- The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. The premises were sometimes not cleaned.
- The design and use of facilities, premises, and signage did not always keep people safe.
- Although the department predominantly had enough registered nurses on duty on most shifts, there were not enough health care support workers and medical staffing levels were reliant on locum and agency staffing. Medical staff compliance with mandatory training was low for some modules, including life support and safeguarding.
- Staff were not always able to respect patients' privacy and dignity in the corridor waiting areas.
- People did not always receive the right care promptly. Delivery of care in a timely manner was not always sustainable during periods of heavy demand.
- Although the service leaders monitored performance and had escalation plans and processes for managing periods of heavy demand, a number of initiatives to address performance issues were still embedding and were not always effective in reducing the risks and the impact on performance.
- Key performance metrics including ambulance handover times, waiting times from referral to treatment and arrangements to admit, treat and discharge patients, 12-hour trolley waits, and total time in the department were not in line with national standards or trust internal targets.

Urgent and emergency services

However:

- Despite the concerns around training compliance for medical staff, staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff carried out daily safety checks of specialist equipment and mostly disposed of clinical waste safely.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough medical and nursing 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 medical, nursing and healthcare support worker levels and skill mix.
- The service used systems and processes to safely prescribe, administer, record and store medicines and prescribing documents in line with the provider's policy. Staff monitored patients regularly for pain and provided pain relief quickly.
- The service had worked with other primary, community and social care providers to develop a range of care and treatment pathways to direct patients away from the department to community-based services more appropriate to the patients' needs.
- Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced including factors external to the service arising from the additional pressures of the COVID-19 pandemic. They were visible and approachable in the service for patients and staff.

Is the service safe?

Requires Improvement ● ↓

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

Safeguarding

- Not all staff had received training on how to recognise and report abuse to the right level for their role. However, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.
- Staff screened paediatric patients on arrival at the department and at assessment for any safeguarding concerns.
- At the time of our inspection, low numbers of medical staff had completed level three safeguarding training for the protection of adults and children. Although most medical staff had completed level one and level two training (82% for adults and 87% for children) this meant the overall safeguarding training compliance rate for medical staff was 65%. However, medical staff understood how to protect patients from abuse.
- Most nursing staff had training on how to recognise and report abuse and they knew how to apply it. The overall safeguarding training compliance rate for nurses over all three training levels was 91%. However, of this, safeguarding level three training compliance was 64%.

Urgent and emergency services

- Most healthcare support workers were eligible for level one and two training in safeguarding adults and safeguarding children; 91% of these staff had completed these modules.

Cleanliness, infection control and hygiene

- The service did not always control infection risk well. Although the hospital had systems and processes to reduce and mitigate the risk of infection, staff did not consistently comply with the control measures to protect patients, themselves and others from infection.
- Staff did not always maintain social distancing between patients or themselves. We saw six staff members not maintaining social distance in an office next to the green (non-COVID) resuscitation area. Staff workstations within the department were close together which limited staff ability to socially distance when updating patient records.
- Staff, patients and ambulance crews were not always able to maintain social distancing in the corridors. Patients on trolleys were positioned 'head to toe'. However, we saw a chair placed next to the end trolley for ambulatory patients prevented social distancing with the patient on the trolley.
- We witnessed a relative being directed to the urgent treatment centre without any COVID screening.
- On multiple occasions we saw that staff did not adhere to hand hygiene protocols; alcohol gel was used but this was not consistent. We noted a staff member taking a patient's history on the respiratory corridor without eye protection. Another staff member interacted closely with patients and the immediate physical environment, without using gloves and without washing hands or changing PPE between patients.
- Staff did not always change personal protective equipment (PPE) when moving between different areas, such as between the paediatric department and the adult major's area. In some cubicles, PPE storage was at the foot of the bed which prevented staff from maintaining an appropriate social distance from the patient when putting on or taking off their PPE.
- Although staff cleaned cubicles and equipment between patients, cleaning of the floor area was not consistent. We also saw that the department's patient assisted transfer board was not always decontaminated after use by external partner staff. This increased the risk of cross contamination or cross infection of patients and staff.

Environment and equipment

- The design and use of facilities, premises, and signage did not always keep people safe. Not all areas of the environment were appropriate for the care and treatment provided.
- Space was limited in the department. At times doorways were temporarily blocked; for example, the hot food trolley was left plugged in blocking the doorway to the green resuscitation area and the fire extinguisher. Staff told us this was a regular occurrence.
- The physical size of the corridors restricted the ability for department staff, ambulance crews and patients to socially distance to two meters. During periods of high demand, it was not easy for staff to move patients on trolleys through the ambulance/respiratory corridor.
- Ambulance crews arriving with patients, whose COVID-19 status was unknown, brought patients through the respiratory corridor. This increased the potential risk of cross infection for any patients, who were COVID-19 negative, brought through the corridor by ambulance crews.
- Signage in the department was not always effective; we saw patients accessing the respiratory corridor in error.
- The service had repurposed the plaster room into a temporary mental health assessment room. The room was not fully suitable for this purpose. There was only one entrance and exit door and this did not have an observation

Urgent and emergency services

window. Though some fittings had been boxed in there were sharp edges to these and to the cupboards. Managers told us the room had been assessed for ligature risks and issues with the suitability of the room. These had not been recorded on formal risk assessment documents but were noted on the department's risk register. After the inspection, the service undertook a formal risk assessment of the room and provided a copy of the assessment to us. However, this showed there were some gaps in assurances.

- Although a vital signs observation machine was allocated to each corridor, staff told us access to observation machines could be delayed whilst they were being charged. There was a risk this could delay vital sign observations for patients waiting on the corridors.
- Staff carried out daily safety checks of specialist equipment, and mostly disposed of clinical waste safely.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, during periods of high demand, long waits to be seen, treated, discharged or admitted meant that patients could be exposed to an increased risk of harm.
- Care was mostly provided in a safe way; however, training compliance rates for advanced life support and paediatric advanced life support were low across all staff groups. Adult basic life support training rates were over 80% for eligible nurses and healthcare support workers. Training compliance rates for advanced life support was lower at 49% and 48%, and advanced paediatric life support for registered nurses was 48%. For medical staff, training rates were low at 45% for basic life support and 47% for advanced paediatric life support. Training for adult advanced life support was significantly low at 23%.
- Staff followed trust policy to stream patients to the most appropriate area on arrival. Shift changes and handovers included all necessary key information to keep patients safe.
- Reception staff used and were able to describe protocols to screen and stream patients. This included patients with suspected COVID-19, cardiac symptoms or to the urgent treatment service for emergency department triage. They could also refer patients to the minor injuries service or for the primary care services operated by the urgent treatment centre. Paediatric red and amber pre-alert systems were used to maximise effectiveness in the paediatric emergency department.
- Patients were triaged and prioritised in line with the trust policies. Between November 2019 and November 2020, the median time for arrival to initial assessment varied between six minutes and 11 minutes with the lower figure achieved in May 2020. This was within the national target for arrival to initial assessment of 15 minutes.
- Staff mostly completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly including after any incident. There were some gaps in pressure ulcer assessment; however, staff provided mattress toppers for patients waiting on trolleys to minimise the risk of pressure damage.
- Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated their care appropriately. Staff monitored patients for signs of sepsis using the Sepsis Six tools. Sepsis treatment packs were available. Our records review showed that four patients at risk of sepsis were prescribed and administered antibiotics in an appropriate timescale. Sepsis audit data for the emergency department, data between April and October 2020 showed 83.4% compliance with the Sepsis Six standards.
- The service participated in audit of its performance against the Royal College of Emergency Medicines clinical standards. Audit data showed 83.4% compliance with the Sepsis Six standards between April and October 2020. The service had action plans for addressing areas of improvement, although the copies provide to us were undated.

Urgent and emergency services

- Staff monitored patients' vital signs and recorded these on the department's electronic system which calculated the national early warning score (NEWS). Staff escalated care to doctors appropriately when triggered by the NEWS score. Staff monitored patients for signs of pain and pain relief was prescribed and administered in an appropriate time. Senior nurse audit of risk assessments in October 2020 showed 100% compliance with triage, national early warning score recording, falls risk assessment, Purpose T skin assessment, and triage.
- Staff compliance with the requirements of the trust's Standard for Adult Patient Observation Practice was audited in September 2020. The audit results showed improvement in some areas but weakness in others and an action plan had been developed to address these. However, the audit samples were taken from across the division of medicine and the report was not disaggregated by unit or ward. This meant we were unable to determine how the emergency department performed in the audit.
- The resuscitation areas appeared well staffed and the critically ill patients in the department at the time had been seen in an appropriate timescale and treated appropriately. Training rates for nurses and health care assistant staff were above 80% for basic life support, although just under half of eligible staff in these groups had completed adult and paediatric advanced life support training. For medical staff; just under half of eligible doctors had completed basic and advanced life support training and less than a quarter of staff had completed paediatric life support training.
- Staff reported no issues with escalating to a doctor for review. Patients referred to the medical speciality were reviewed by the medical doctors in the department whilst waiting for a bed.
- We saw that the patient safety checklist was embedded and well used. Senior nurse audit of safety checklist completion in October 2020 showed 82% compliance. While patient records were mostly of a good standard, we saw one patient had few notes recorded on the department's electronic patient record system. We saw another patient had waited for three hours for review by a doctor and their patient safety checklist had not been completed.
- The service had 24-hour access to mental health liaison and specialist mental health support.

Nurse staffing

- The service mostly had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed staffing levels and skill mix.
- Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. During our inspection the number of nurses and healthcare assistants matched the planned numbers.
- We reviewed the registered nurse (RN) and health care support worker (HCSW) rotas and the fill rates for the adult emergency department for the period 16 November to 6 December 2020. These showed the department had enough registered nurses on duty on most shifts, but there were not enough health care support workers.
- The service used a mixture of its own staff through the NHS Professionals bank system and regular agency staff to fill empty shifts.
- The department manager could adjust staffing levels daily according to the needs of patients. The service had a minimum of two registered paediatric nurses available per shift. There is also a paediatric nurse consultant, and a paediatric advanced care practitioner based in the emergency department. This met the standard in the Royal College of Paediatrics and Child Health guidance *Facing the Future: Standards for children in emergency care settings* (2018).

Urgent and emergency services

- The service provided relevant competency and mandatory training to staff within both the adult and paediatric department to enable flexibility and cross-cover for gaps in the staffing rota. It also worked closely with the hospital's paediatric observation and assessment ward to support and gaps in the rota.
- Staff we spoke with told us the staffing establishment had been increased for the paediatric unit due to the expected expansion of the service. Although the staff had been recruited and were in post, the building work had been delayed. This meant there were times when the paediatric unit was overstaffed, giving the flexibility to use staff more effectively across the service.

Medical staffing

- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service had a good skill mix of medical staff on each shift and managers reviewed the staffing levels and skill mix regularly.
- We reviewed medical rotas for the week of the inspection, and the two weeks prior to inspection. These showed there were sufficient numbers of consultants for the number of patients attending the service.
- Consultant cover was available 16 hours per day seven days a week. The service always had a consultant on call overnight.
- The service had a paediatric emergency consultant. This met the standard in the Royal College of Paediatrics and Child Health guidance *Facing the Future: Standards for children in emergency care settings* (2018).
- Although locum usage was low at 6.5%, agency usage was high at 25.8%. However, from our review we could see that the service used regular locum and agency staff who were familiar with the service.

Medicines

- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy.
- Medicines were prescribed and administration recorded on the trust's electronic prescribing and medicines administration system.
- Temperature sensitive medicines were stored in two refrigerators within the department. However, despite checks of fridge temperatures as part of the pharmacy stock top-up checks, we noted that the temperature had not been recorded on four occasions during the month of November.
- The hospital's pharmacy team undertook stock top-up checks. We reviewed a random sample of medicines and found these were all in date. The controlled medicines register was completed appropriately.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Pharmacy teams undertook monthly safe and secure medicines audits, which included details of any medicines alerts.
- Compliance with the safe and secure medicines audits were included in a quarterly medicine management report to the hospital's clinical effectiveness committee. The November 2020 audit showed an average compliance rate of 85% across the four areas of the department (Majors A&B and the two resuscitation areas).

Urgent and emergency services

Is the service responsive?

Requires Improvement   

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

Access and flow

- People could access the service when they needed it but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Managers and staff monitored waiting times but could not always ensure that patients did not stay longer than they needed to.
- The urgent and emergency care service was available 24-hours a day throughout the year.
- High demand for the service and bed capacity issues in the wider hospital meant that some patients waited longer to be seen and treated or admitted to hospital than expected. Managers told us about initiatives such as, improved community pathways deflecting patients to primary and community services, increased staffing establishment, bed meetings, and mutual aid from other hospitals in the region. Data we reviewed showed the number of patients attending the department had reduced from 10072 during October 2019 to 7909 during October 2020. Despite this, patients spending more than 18 hours in the department had increased from 118 in October 2019 to 367 in October 2020. There was little evidence of positive impact on flow through the department from measures the hospital and service had put in place.
- The service's performance data showed a deteriorating picture, particularly from August 2020 to October 2020. November 2020 data provided after the inspection continued to show a deteriorating trend in most key metrics.
- The service's performance data showed a deteriorating picture in ambulance handovers greater than 60 minutes from 19 in August 2020 to 103 in October 2020 when 2163 (21%) fewer patients attended than in October 2019. In the week before inspection, 20% of ambulances arriving at the hospital waited between 30 and 60 minutes and nearly 6% waited more than 60 minutes to hand over their patient to department staff. During our inspection, the longest wait we saw for a patient's care to be taken over by staff from the ambulance crews was 1 hour 30 minutes. We saw ambulance crews having to care for two patients whilst they waited to be handed over to hospital staff in order to release the other crew and ambulance.
- The service's performance against the four-hour standard to admit treat or discharge patients also deteriorated from 81.7% in August 2020 to 66.4% in November 2020.
- During August 2020, one patient waited longer than 12 hours to be admitted after a decision to admit had been made and this had deteriorated in November 2020 when 271 patients waited longer than 12 hours.
- During August 2020, 51 patients were in the department longer than 18 hours and by November 2020 this had risen to 439 patients.
- Although staff told us patients were frequently in the department for 20 hours or more, we did not witness this. At the time of our visit several patients were in the department for between 5 and 9 hours; however, all the patients had been reviewed, had regular observations and early warning scores recorded.
- During our inspection, at 1pm, one patient had been in the department for 14 hours, seven had been in the department for more than four hours, and three were approaching the four-hour standard.

Urgent and emergency services

- The longest wait from the decision to admit was 8.5 hours. This patient was registered in the department at 11.40pm the previous day, the decision to admit was made at 5.10am and the patient was still waiting for admission at 1.40pm.
- By 4pm, six patients were approaching the four-hour standard, 12 patients had been waiting over four hours, and one patient had been in the department over 11 hours. Five of these patients had a decision to admit and the longest waiting time from the decision to admit was 5.5 hours.
- However, the number of patients leaving the service before being seen for treatment was low. From November 2019 to November 2020 an average of 2.4% of patients left the department without being seen. This was better than the trust's target of less than 5% of patients leaving the department without being seen. In October 2020, this figure was 1.9% which was better than the national average of 2.2%.
- Although staff treated patients with compassion and kindness patients' privacy and dignity was not always maintained in the corridors during periods of high demand, particularly when physical examination was required, and the allocated cubicle was already in use. Privacy screens were available, but staff told us there were insufficient screens to be able to provide full privacy and dignity for all patients in the corridor. Staff also told us they did not always use the screens due to the pace of work required.
- The high demand for, and lack of flow through, the service meant that staff were not always able to follow policy to keep patient care and treatment confidential. We saw initial assessment and ongoing observations being taken in the corridor when no cubicle space was available. We saw staff taking a patient's history on the corridor near other patients, and other staff members delivering care, inserting a catheter and giving an injection on the corridor. However, these actions also meant patients were receiving care and treatments they needed.
- Staff mostly supported and involved patients to understand their condition. We spoke with three patients and one relative. All three patients told us that staff had kept them updated on their condition, their care and progress towards when they would next be seen. The patients we spoke with were generally happy with the level of care they had received at that point of time.
- One family member who had been able to accompany their relative told us they had been informed about the plans for their relative after they had specifically asked staff. The service had access to electronic tablets to support unaccompanied patients in communicating with their relatives.
- Staff were able to support the needs of patients attending with mental health symptoms through referral to the mental health liaison team who were located within the department.

Is the service well-led?

Good   

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

Leadership

- Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced including factors external to the service arising from the additional pressures of the COVID-19 pandemic. They were visible and approachable in the service for patients and staff.
- Staff told us the service's leaders were visible and approachable. Throughout the inspection we saw the lead nurse walking round the department, speaking with and supporting staff.

Urgent and emergency services

- One staff member told us they felt supported by the service's leaders when experiencing increased demand due to flow issues and in escalating to the specialities in the hospital when needed.
- Staff told us that senior nurse walk-rounds occurred regularly and there has been an increased communication from, and visibility of the hospital and trust executive team.

Culture

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care, including during periods of heavy demand. The service had an open culture where staff could raise concerns without fear.
- During the inspection we saw that all staff throughout the department worked well together and appeared to be a strong, cohesive and well-functioning team. Nursing staff we asked spoke positively about the services leaders and told us they felt supported by them and told us they felt 'well looked after', that it was a 'happy department' and it felt 'like a family'. Junior doctors we spoke with equally felt well supported by their senior and consultant colleagues.
- Some staff expressed frustration that they were not always able to give the quality of care they would aspire to patients on the corridors during periods of heavy demand; however, we did not observe any significant lapses of care during our inspection.
- The service had introduced a number of initiatives to support staff, including 'wobble-rooms' for staff to use if they were upset or needed some time to compose themselves during a shift. Psychological wellbeing support was available to staff through the trust, and through the Greater Manchester health and care staff wellbeing hub.
- A staff pulse check survey reflected staff safety concerns related to COVID-19, although the results were similar to other staff groups and departments within the hospital. However, the survey showed that staff felt much better informed than the rest of the organisation in relation to where they could access health and wellbeing support, the actions the organisation was taking to support them in this, and that their line managers took a positive interest in staff health and wellbeing.

Managing risks, issues and performance

- The service's senior clinical leadership team were able to describe the current issues that were impacting on the service's performance and response times. These included factors outside the service's control within the wider hospital and the community across the Greater Manchester region as a result of pressures from the COVID-19 pandemic that were leading to increased demand on the service and directly impacting on waiting times and performance.
- The leaders were able to describe a range of initiatives that had been or were in the process of being put in place. For example, community pathways and services designed to deflect attendances away from the department to more appropriate primary or community based health or adult social care services. However, these were still embedding and flow through the department remained a concern.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However, a number of initiatives to address performance issues were still embedding and were not always effective in reducing the risks and the impact on performance. This meant that delivery of care in a timely manner was not always sustainable during periods of heavy demand.

Urgent and emergency services

- The service's clinical leadership team were able to describe the main risks faced by the service, and these were reflected in the service's risk register along with controls and mitigation actions. The two top risks identified were overcrowding due to capacity and demand including the impact on the ability to maintain social distancing between staff and patients. Limited isolation facilities to undertake aerosol generating procedures was also an identified risk.
- The service's clinical leadership team described the internal and external factors that directly impacted on and contributed to the deterioration of the service's performance. This included the flow in the hospital and delays in discharging inpatients to the community. The leaders described the initiatives the service was implementing internally, such as the new nurse co-ordinator role in the department and in-reach from medical consultants and therapy teams. Similarly, they described initiatives with external partners to reduce demand on the service, including a range of community and primary treatment pathways to deflect patients to more appropriate care services, and to improve flow within the hospital and the department.
- However, we did not see these reflected in the service's key performance figures which, due to increasing demand on the service, were continuing to deteriorate. The leaders told us that some oversight, particularly of the four-hour treat, admit or discharge target had been lost during the second wave of the pandemic. For example, there was a continuous drop in the four-hour performance from 86.7% in July 2020 to 66.4% in November 2020. In addition, 12-hour trolley waits increased significantly from 19 during November 2019 to 271 in November 2020. Some senior operational staff in the department told us that although service leaders escalated capacity and demand issues using the agreed escalation pathway, this did not always change the situation.
- The service had effective systems of clinical effectiveness and performance governance meetings monthly which included review of range of internal operational and service delivery audits undertaken in the department. These had clear escalation routes through the division, the care organisation leadership, and to the board. Information and shared learning was fed back to staff in monthly team meetings, handovers, emails and newsletters.

Areas for improvement

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

MUSTS

Urgent and emergency care

- The trust must ensure that staff in the service prevent and control the spread of infection by adhering to the trust infection prevention and control policy in relation to hand hygiene. (Regulation 12(1))
- The trust must ensure that staff in the service prevent and control the spread of infection by adhering to the trust infection prevention and control policy in the use of personal protective equipment at all times and in all areas. (Regulation 12(1))
- The trust must ensure that staff in the service prevent and control the spread of infection by adhering to trust infection prevention and control policy in maintaining patient and staff safety through social distancing. (Regulation 12(1))
- The trust must ensure that staff in the service prevent and control the spread of infection by adhering to trust infection prevention and control policy and cleaning protocols when cleaning cubicle spaces between patients. (Regulation 12(1))

Urgent and emergency services

- The trust must improve the flow of patients through the emergency department and the hospital so that patients are assessed, treated, admitted and discharged in a safe, timely manner. (Regulation 12(1))
- The service must ensure that care is provided in line with national performance standards. (Regulation 12(1))
- The trust must ensure the service maintains patients' privacy and dignity at all times on the corridors when undertaking confidential conversations, assessments and providing treatment. (Regulation 10(1))
- The trust must ensure that staff in the service have the appropriate qualifications, competence and skills through completion and are compliance with all levels of life support training appropriate to their role. (Regulation 12(1))
- The trust must ensure that, where the service continues to use the temporary mental health assessment room, the room is compliant with the standards set out in the Psychiatric Liaison Accreditation Network's Quality Standards for Liaison Psychiatry Services (Regulation 15(1))

SHOULD

Urgent and emergency care

- The trust should continue to monitor staff compliance with recording fridge temperatures and consider reminding staff of the need to check with pharmacy when the fridges are noted to have gone out of range.
- The trust should consider reviewing the service's healthcare support worker fill rates once the newly recruited staff are in post to determine if this has had a positive impact on the fill rates.
- The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors on-site, two specialist advisers and two offsite inspectors. The inspection team was overseen by Karen Knapton, Head of Hospital 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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment