Great Western Hospitals NHS Foundation Trust

Great Western Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

We previously visited the Great Western Hospital in September 2015 when we carried out a comprehensive inspection of the services provided. We raised a number of concerns following this inspection in relation to the emergency department. Our concerns in relation to safety were significant and we judged that the governance systems and processes in place were not effectively operated and, as such, were not able to demonstrate effective management of risks, effective clinical governance, continuous learning, improvements and changes to practice from reviews of incidents, complaints and mortality and morbidity reviews.

In December 2015, in light of these concerns, we took enforcement action and required the trust to make significant improvements. The trust submitted a comprehensive improvement plan and provided us with monthly progress reports.

In April 2016 we carried out an inspection to check progress against the concerns raised in the warning notice. We found that significant progress had been made but the requirements of the warning notice were not fully met. Our remaining concerns were:

- Risks to patient safety were not always addressed in a timely way.
- Accurate and up-to-date records of care and treatment were not consistently maintained to ensure that patients were protected against the risk of inappropriate care and treatment.
- Staff did not consistently comply with safety systems in place to identify seriously unwell or deteriorating patients.
- The emergency department was not consistently staffed to ensure that defined safe staff to patient ratios were met. There was insufficient reporting or scrutiny of staff concerns with regard to staffing levels and capacity.
- We had continuing concerns about the safety of patients and staff in the emergency department observation unit. Plans to relocate or reconfigure the unit to improve safety had not been finalised.
- There remained a significant number of gaps in nurse training. A training plan to address identified gaps had not been developed and management oversight of this had yet to be implemented.

In October 2016 we conducted a second follow up inspection of the emergency department. At the time of this visit, we were aware that the emergency department and the hospital had continued to experience unprecedented demand for unscheduled care. This was reflected in the trust's performance against key targets. In the period July to September 2016 the trust consistently failed to meet the following targets:

- 85% of patients were triaged within 15 minutes of arrival (patients arriving by ambulance) against a target of 95%;
- The median time patients waited to be seen was 70 minutes, compared with the target of 60 minutes;
- 80.1% of patients were discharged, transferred or admitted within four hours, compared with the target of 95%.

We found that further and sufficient progress had been made to meet the requirements of the warning notice. Our key findings were as follows:

- Record keeping had improved through ongoing training and coaching. Audits showed an improving picture in relation to the frequency with which staff observed patients' vital signs and calculated early warning scores to identify deteriorating patients.

Summary of findings

- There was improved oversight of staffing, capacity and safety in the emergency department by the nurse in charge. Regular situation reports had been introduced and these ensured managers were informed of risks and concerns were escalated. Steps were being taken to reduce the risks associated with the employment of temporary staff. The department was exploring innovative ways to improve staff recruitment and retention.
- Governance systems had been further strengthened. Risks were well understood and regularly discussed. Audits were used to drive service improvement. There was greater oversight of nurse staff training and supervision.
- Steps had been taken to better equip staff to care for mental health patients on the observation unit. Plans had been agreed to make alterations to the premises to create a safer environment for patients and staff. Incidents relating to the management of mental health patients had reduced significantly.

However, there were also areas where the trust needs to make further improvements:

- We had continuing concerns that the emergency department was not able to consistently meet defined safe staff to patient ratios at times of overcrowding. Staff shortage was a continuing problem and there were concerns about a lack of senior and experienced nursing staff. There was heavy reliance on temporary staff and there were concerns about their competence. Notwithstanding the risk this posed to patient safety, this affected staff morale, recruitment and retention.
- We were concerned about a lack of pace in addressing risks identified by a serious incident which occurred in May 2016. We were also concerned that learning had not been embedded in staff practice following a similar incident which occurred in 2014. Staff awareness of risks and learning from adverse events needed to improve.
- Despite improvements in record keeping, we judged there was room for further improvement and consistency, to ensure that patients are protected against the risk of inappropriate care and treatment.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Great Western Hospital

Detailed findings

Services we looked at
Urgent and emergency services.

Detailed findings

Contents

Detailed findings from this inspection	Page
Our inspection team	5
How we carried out this inspection	5
Findings by main service	6

Our inspection team

Our inspection team was led by Elaine Scott, Inspector, Care Quality Commission. The team included a second CQC inspector and a specialist advisor (an emergency nurse practitioner).

How we carried out this inspection

The inspection was conducted unannounced. We visited the emergency department on 5 October 2016. We spoke with the department's management team, nursing and support staff. We reviewed information provided by the trust, prior to, during and following the inspection. We spoke with NHS Improvement and reviewed information we hold about the trust.

Notes

We have not rated this service because of the limited focus of our inspection, which did not include all domains or all components of each domain.

Urgent and emergency services

Safe	
Effective	
Well-led	
Overall	

Information about the service

The unscheduled care division provides urgent and emergency services at Great Western Hospital (GWH). The emergency department (ED) operates 24 hours a day, seven days a week.

Adult ED patients receive care and treatment in two main areas: minors' and majors'. Self-presenting patients with minor injuries are assessed and treated in the minors' area.

Patients with serious injuries or illnesses who arrive by ambulance are seen and treated in the majors' area, which includes a resuscitation room. The majors' area is accessed by a dedicated ambulance entrance.

There is a dedicated children's unit with a separate waiting area and a treatment area with five private cubicles.

Patients who present with minor illnesses may be redirected to the nurse-led urgent care centre located on the GWH site or to the co-located GP out-of-hours service. This unit did not form part of this inspection.

The ED is a designated trauma unit and provides care for all but the most severely injured trauma patients. Severely injured trauma patients are usually taken by ambulance to the major trauma centres in Bristol or Oxford if their conditions allow them to travel directly. Such patients are otherwise stabilised at GWH before being treated or transferred as their conditions dictate. The ED at GWH is served by a helipad.

There is an eight-bed observation unit that allows for further assessment of patients who are likely to require care and treatment for between four and 24 hours but are unlikely to require admission.

Summary of findings

This was the second follow up follow up visit to the emergency department to assess whether the trust had made sufficient progress in response to the Section 29A warning notice issued in December 2015, following a comprehensive inspection in September 2015. At our last visit in April 2016 we saw that significant progress had been made but the requirements of the warning notice had not been fully met.

At our most recent inspection we saw further improvements and judged that the trust had made sufficient progress to meet the requirements of the warning notice.

We found:

- Record keeping had improved through on-going training and coaching. Audits showed an improving picture in relation to the frequency with which staff observed patients' vital signs and calculated early warning scores to identify deteriorating patients. A new safety checklist had been introduced and this was being championed by senior nurses. Additional patient monitoring equipment had been provided and electronic monitoring equipment was to be introduced in April 2017.
- There was constant, close 'real time' oversight of staffing, capacity and safety in the emergency department by the nurse in charge. Regular situation reports had been introduced and these ensured managers were informed of risks, and concerns were escalated.
- Steps had been taken to reduce the risks associated with the deployment of temporary staff. This included block booking temporary staff to ensure

Urgent and emergency services

familiarity and continuity. The trust had also set out in detail to agencies, the required competencies of agency nurses employed in the emergency department.

- Steps had been taken to better equip staff to care for mental health patients on the observation unit. Plans had been agreed to make alterations to the premises to create a safer environment for patients and staff. Incidents relating to the management of mental health patients had reduced significantly.
- Audits were used to drive service improvement. We saw evidence of learning and changes in practice following audits.
- The appointment of a clinical facilitator had resulted in greater oversight and a more structured approach nurse staff training and supervision. Nursing staff had rostered training days once a month.
- Risks to safety and performance were well understood. There was a strong local management team, who were focussed on improvement, and who were well supported and empowered by the executive management team. Staff felt supported by local managers, who were visible and accessible. Staff felt there was greater understanding at executive level of the pressures the department faced.
- Positive steps had been taken to improve staff engagement and staff education and, in turn, improve staff morale and retention.
- There was an effective governance framework, ensuring a good understanding of performance and risk at departmental, divisional and executive levels.

However:

- We had continuing concerns that the emergency department was not able to consistently meet defined safe staff to patient ratios at times of overcrowding. Staff shortage was a continuing problem and there were concerns about a lack of senior and experienced nursing staff. There was heavy reliance on temporary staff and there were concerns about their competence. Notwithstanding the risk this posed to patient safety, this affected staff morale, recruitment and retention.
- We were concerned about a lack of pace in addressing risks identified by a serious incident which occurred in May 2016. We were also concerned that learning had not been embedded in staff practice following a similar incident which occurred in 2014. Staff awareness of risks and learning from adverse events needed to improve.
- Despite improvements in record keeping, we judged there was room for further improvement and consistency, to ensure that patients are protected against the risk of inappropriate care and treatment.

Urgent and emergency services

Are urgent and emergency services safe?

- At our previous inspections we were concerned that processes were not sufficiently robust to ensure that learning and improvement took place following incidents. At our most recent inspection we found that risks to patient safety were regularly discussed at governance meetings and learning from incidents was identified and acted upon. However, we were concerned that some staff continued to be unaware of serious incidents and learning from them. A serious incident which occurred in May 2016 had been fully investigated and there was a comprehensive action plan to put learning into practice. We were concerned however, at the lack of pace with which remedial actions were put in place. We were also concerned that learning from a similar incident in 2014 had not been embedded in practice.
- We previously raised concerns about nurse staffing levels in the emergency department and the department's ability to adjust staffing levels to ensure safe staffing levels were maintained when the department was over capacity. The emergency department had received a significant uplift (approximately 20%) in nurse staffing following our inspection in September 2015. However, at our most recent inspection, recruitment and retention remained challenging and the department was not fully staffed. There were concerns about the skill mix in department, with a shortage of senior and experienced nurses. Shifts were filled to planned levels consistently and two additional nurses were employed to support the department when it was over capacity. However, when the department was overcrowded, which was a regular occurrence; defined staff to patient ratios were not consistently met. There was heavy reliance on temporary staff. Staff and managers had concerns that their skills and experience were not commensurate with those of permanent staff. Staffing and capacity were closely monitored and there were systems in place to escalate concerns around capacity. The department was taking steps to reduce the risks associated with the employment of agency staff, through block booking and training, and developing strategies to improve recruitment and retention of permanent staff.
- Following our previous inspection in September 2015, the children's emergency department had received an uplift in staffing. The trust committed to provide training to more adult-trained nurses to acquire additional skills to care for children. In April 2016, staffing was much improved. Despite this, at our most recent inspection, concerns continued to be expressed by staff that the department was not consistently staffed by suitably qualified nurses. Recruitment and training was ongoing to address this.
- We had previously raised concerns that nursing documentation was not always completed fully or contemporaneously. At our most recent inspection we saw that record keeping had improved. Nursing documentation had been revised and a new safety checklist introduced, although its use was not yet embedded. Staff training and coaching was on-going. Regular documentation audits were taking place and results showed improvement, although we judged there was still room for further improvement. We found that contemporaneous records of nursing care in the emergency department were not consistently maintained.
- Steps had been taken to mitigate risks in relation to the location and unsuitable layout of the observation unit. Plans to reconfigure the layout of the observation unit had been finalised, although building works would not begin until the spring of 2017. In the meantime, steps had been taken to ensure staff were better equipped to support people with mental health needs and keep them and other patients safe. The number of incidents reported which related to the management of mental health patients had significantly reduced.

Incidents

- Risks to patient safety were regularly discussed at governance meetings and learning from incidents was identified and acted upon. However, we were concerned that some staff continued to be unaware of serious incidents and learning from them.
- At our previous inspections in September 2015 and April 2016 we raised concerns that the emergency department did not always take swift and appropriate remedial actions in response to incidents.

Urgent and emergency services

- At our most recent inspection we were told about a serious incident which occurred in May 2016 involving an intoxicated patient who had sustained a head injury. The trust had undertaken a root cause analysis (RCA) of this incident. The RCA report, identified there had been a delay in recognising the seriousness of the patient's head injury. Contributing factors included:
  - Busy department. High numbers of acutely unwell patients and long waits (two to three hours) to be seen, patients were not moved out of the emergency department, despite beds being available;
  - Poor staff skill mix- agency staff and inexperienced staff;
  - Inexperience of the nurse who undertook the initial assessment, leading to their failure to follow the triage process correctly and to escalate appropriately. The nurse had been qualified for less than a year and had worked in the department for only a few months;
  - Failure to document and act on early warning scores and neurological observations, leading to a delayed computerised tomography (CT) scan;
  - Failure to follow National Institute for Health and Care Excellence (NICE) guidance in respect of the management of head injuries.
- We had previously raised concerns about the trust's failure to take appropriate and timely action in response to a similar serious incident which occurred in 2014. The root cause analysis report relating to this most recent incident recommended that there should be a facilitated review to explore the reasons for failure to learn from the serious incident.
- An audit of the management of head injuries in intoxicated patients had taken place in June 2016 and had shown poor compliance with NICE guidance. An action plan was in place. It was planned to re-audit compliance one training had been completed.
- The trust told us they had taken a number of actions in response to both the serious incident and the audit findings. This included staff training, and the display of guidance in relation to the management of head injuries in assessment cubicles in the majors' area. We noted however, that the head injury guidance was not displayed in the minors' assessment area.
- It was noted in the RCA report that immediate actions following the incident had included communication and education with the team regarding patients with a head injury. During our inspection six nursing staff told us they were unaware of the serious incident or learning from it.
- Peer to peer training in the identification and management of a head injury had been taking place in the emergency department. At the time of our inspection five staff had received this training and a further two sessions were scheduled in October 2016. It was anticipated that all staff would receive the training in the next three months.
- In accordance with the action plan developed following the investigation, the emergency department had developed a staff training and competency package in triage. The Royal College of Emergency Medicine recommends in its Triage Position Statement (2011) that "staff undertaking [triage] should be registered healthcare professionals experienced in emergency/urgent care who have received specific training…" and "Individual departments should have an agreed and documented triage training process for staff which is auditable." The target completion date for delivery of this training was 30 September 2016. We were told that staff training had begun at the beginning of October 2016, with four staff signed off as competent at the time of our inspection and all other permanent staff working towards this. The senior matron told us they anticipated that all staff would be trained within 10 weeks.
- Incidents, themes and learning were discussed at monthly governance meetings; however some staff reported little knowledge of learning from such events. Members of the executive management team had recently visited the emergency department to explore issues emerging as a result of another serious incident, which occurred in September 2016 on the acute medical unit (involving a patient who had been admitted via the ED). They had similarly identified a lack of awareness among some staff. They reported that senior staff were well informed about incidents and learning from them. However, they reported: "Junior staff broadly unaware of key changes made in response to SIs [serious incidents] and 'Warning Notice' from CQC. Staff nurses x 2 were not sure how

they would get to know about serious incidents etc. unless they had been involved in the incident themselves, although another said incidents were discussed in the safety briefing."

- Minutes of governance meetings were shared with staff but some reported that they were too busy to read them. Safety briefings took place at each staff handover but staff told us information was brief and focused mainly on real time safety issues relating to individual patients and departmental issues, such as such as staffing and equipment. We found this was the case in the sample of notes from these briefings, which we reviewed.Staff confirmed however, that they did receive regular reminders about the importance of recording vital signs and calculating NEWS scores.
- At our previous inspections we had raised concerns about the safety of staff and patients on the observation unit. In particular, we had concerns about the number of incidents reported which related to the management of mental health patients. At our most recent inspection, we saw that there had been a significant reduction in such incidents. Staff had received advanced conflict resolution training and a registered mental health nurse continued to be employed to support patients with mental health issues. Staff had been issued with personal alarms to improve their safety.
- We also raised concerns that learning had not been embedded in relation to prevention of falls, following a serious incident on the observation unit where a patient had sustained a serious injury following a fall. At our most recent inspection we saw evidence that risk assessments were taking place in respect of falls and staff took appropriate steps to prevent patients from falling.

Environment and equipment

- At our previous inspection in September 2015 we raised concerns about the location, design and layout of the observation unit. The department was physically separate from the emergency department and this led to a feeling of isolation and vulnerability of staff working there. The trust had recognised the risk and a project group had been established to review the short and long term direction of the observation unit, including admission criteria, location and facilities. We were concerned about the lack of pace of this project. There were no timescales agreed in which any improvements would take place.
- At our follow up visit in April 2016 plans to reconfigure the department were being finalised, although a time scale for building works was not known. Since then we had been informed by the trust that building works were postponed until the spring of 2017, as the impact on available beds was considered too risky during the busy winter period.
- In the meantime, steps had been taken to mitigate environmental risks to staff and patients. We saw at our most recent inspection that all staff had been issued with personal alarms and support from security guards had been increased. Staff had received training to help them support patients with mental health needs, including conflict resolution training and they were informed about environmental safety, including ligature risks. Registered mental health nurses were employed on every shift to provide close support for patients who were identified as being at risk of harming themselves or others. We were told that from 1 November 2016 the trust would have the support of a mental health liaison nurse 24 hours a day, seven days a week. This nurse would support staff in the ED and the observation unit. It was anticipated that this increased level of input would also help to reduce unnecessary admission to hospital.
- We raised concerns at our inspection in September 2015 about the safety of the children's emergency department. This was a dedicated children's facility located adjacent to the main ED. The department consisted of a waiting room at the end of a corridor, on which four cubicles and a nurses' station were situated. There was no line of sight from the nurses' station to patients in the waiting room or in cubicles (except the cubicle nearest the station which had a window). In April 2016 we saw that a health care assistant was employed at all times to directly observe children and their families in the waiting room. Staff confirmed that this had improved patient safety. However at our most recent visit staff told us that this staff member was sometimes moved to support other areas of the emergency department.

Records

Urgent and emergency services

- At our inspection in September 2015 we raised concerns about the standard of record keeping. Nursing documentation was not always completed fully or contemporaneously. Records audits were not taking place frequently or regularly.
- When we visited again in April 2016, nursing documentation had been reviewed and new documentation had been introduced. Staff training had been provided and regular records audits were taking place. Audits showed that there was still significant room for improvement. Our review of a sample of records during our inspection revealed similar concerns, particularly in relation to the recording of patients' vital signs.
- We reviewed progress at our most recent inspection. Progress in relation to patient observations and early warning scores is reported under 'Assessing and responding to patient risk' below.
- The department had recently introduced a safety checklist which set out elements of basic care and tasks required to be completed and recorded during patients' first four hours in the department. A senior nurse and an audit nurse had been identified to champion this initiative, which had been developed and successfully implemented in another local emergency department. This checklist was appended to the observation chart. We found that this checklist was not consistently completed. We also found that there was little nursing intervention recorded in the free text section of the patient's record, so we did not know, for example, whether patients were offered food and drink or other assistance. It was acknowledged by the management team that the safety checklist would require some refinement to avoid duplication and further education to embed this into practice. Nevertheless, this was a positive development.
- We reviewed a sample of patients' records during our visit. We found that records were not always accurate or complete. We could not be assured of the care and treatment provided. We found:
  - A patient in the resuscitation area had two prescriptions recorded in their notes, which were crossed through. The entries had not been signed and the reason for these being crossed through was not documented.
  - A patient who had been in the department for three hours had regular observations recorded but the safety checklist had not been completed and no other nursing care was documented.
  - A patient in the resuscitation area had two observation charts. One had not been completed with the patient's name. A staff member told us they had started a new chart because the original could not be found. Observations had been recorded as required but no other nursing care was recorded.

Assessing and responding to patient risk

- During our inspection in September 2015 we raised concerns that observations of patients' vital signs and early warning scores were not consistently recorded or taking place with the required frequency. Early warning scores are calculated using weighted scores taken from observation of patients' vital signs. They are used to identify the severity of a patient's illness and to identify deterioration in their condition. The department did not audit the completion of observation charts. We were also concerned that risk assessments were not consistently recorded on the observation unit in respect of patients' risk of falling or self-harm through use of a ligature.
- Following our inspection the trust introduced revised observation charts and nursing documentation. Staff received additional training and regular audits were introduced to monitor compliance. Results showed there was still significant room for improvement and this was evident when we checked a sample of records during our inspection in April 2016.
- At our most recent inspection visit we saw that this issue remained a 'red' rated (high) risk on the unscheduled care division's risk register. There continued to be management focus on improving nursing documentation in relation to patient observations and NEWS scores. Staff were required to record hourly observations of all patients in the first four hours of a patient's attendance. If the patient's stay exceeded four hours, observations were required to be undertaken and recorded as indicated by the calculated early warning score. An early warning score

is calculated by applying a weighted score to recorded observations. A higher score triggers more frequent observation and may require escalation to medical staff.

- The senior matron had written to all staff to set out expectations in relation to the completion of patients' records. There were posters in each patient cubicle to remind staff to complete records. Regular audits continued to take place. Results, plotted on a run chart over the period January to September 2016, showed improvement in relation to the frequency of observations, frequency of NEWS scores calculated and the accuracy of NEWS calculations. In September 2016 the audit scored just over 90% for the first metric, over 95% for the second metric and 100% for the third metric. Additional diagnostic equipment had been purchased and there were plans to introduce an electronic device for recording observations which would sound an alarm when observations were due. This was expected to be introduced in April 2017.
- We looked at a sample of observation charts. We saw improvement overall but inconsistency remained a concern. This meant we could not be fully assured that seriously unwell patients were promptly identified and appropriately managed. We found:
  - Patient 1: observations undertaken hourly and corresponding NEWS scores recorded and correct.
  - Patient 2: first observations recorded at triage 27 minutes after arrival. Thereafter, observations and NEWS scores were recorded with the required frequency;
  - Patient 3: observations and NEWS scores recorded with required frequency (half hourly indicated by NEWS score); however at the time the last set of observations was recorded, there was no NEWS score calculated;
  - Patient 4 (with a head injury admitted to the resuscitation unit) had only one set of neurological observations in a period of nearly three hours;
  - Patient 5 (who had suffered a seizure) had observations recorded shortly after arrival in the emergency department; however, neurological observations were started but not completed. The early warning score was calculated incorrectly. A full set of neurological observations was not fully documented for a further hour and forty minutes, until instructed by the nurse in charge, following a staff handover;
  - Patient 6 (who had suffered a seizure) had only partial neurological observations recorded on admission and these were not repeated in a period of three hours. General observations were recorded but the safety checklist was not completed and no other nursing care was documented.
  - Patient 7 (pregnant and suffering severe diarrhoea and vomiting) was triaged in minors but returned to the waiting room where they waited one hour and 50 minutes before they were seen by a doctor. We asked the nurse in charge why this patient had not been isolated or observed in majors. They were not aware of the patient but immediately arranged for them to be moved to a side room in majors. We looked at the patient's records and saw that the agency nurse who was allocated to care for this patient, had recorded that this patient required four hourly observations. We queried this with a doctor, who confirmed that a minimum of hourly observations should be undertaken, as was the case for all patients in majors.
- The nurse in charge monitored activity and throughput in the department using a live dashboard, from which they were able to identify potential areas of risk, adjust staffing and escalate where required. They also undertook spot checks of nurse documentation.

Nurse staffing

- At our previous inspection in September 2015 we were not assured that the emergency department and the observation unit were consistently staffed with appropriate numbers of suitably skilled and experienced staff to ensure that people received safe care and treatment at all times. When we returned in April 2016, despite a significant uplift in staffing, in the context of unprecedented demand on the service, and difficulties with recruitment and retention, the department continued to struggle to maintain safe staffing levels when the department was over capacity.
- At our most recent visit, staffing continued to be a serious risk. The emergency department continued to

hold a significant number of vacancies. There were 13.5 whole time equivalent (WTE) vacancies, which equated to a vacancy factor of 14.8%. As a consequence, there was heavy reliance on bank and agency staff. It was recorded in the unscheduled care division's risk register: "Patient care is compromised due to high use of temporary staffing within ED. Inexperience, skill mix and leadership is compromised within ED." At a recent ED steering group the senior matron had raised concerns regarding the competence of agency staff. The minutes recorded "[The senior matron] expressed concern that priority assessments could potentially be missed as agency staff did not regularly ask for help when they required assistance."

- The senior matron explained the steps the department was taking to mitigate the risks associated with temporary staffing. Agency staff were block booked, wherever possible, to ensure continuity and familiarity. The senior matron had shared nursing documentation with agencies so that this could be incorporated into their staff training. There was a monthly meeting with agencies where performance issues were discussed. We spoke with one agency nurse who confirmed that they had received training to use the ED observation charts and the early warning system.
- Data provided by the trust showed that planned levels of nurse staffing were mostly achieved and sometimes the department was staffed over planned levels to meet demand, albeit with a significant proportion of bank and agency staff employed. In the three months prior to our inspection bank and agency usage was as follows:
  - July: 35.3% of day shifts and 53.2% of night shifts
  - August: 36.8% of day shifts and 56% of night shifts
  - September: 36.8% of day shifts and 53.3% of night shifts.
- The senior matron told us he was concerned about a lack of experienced nurses; there were 2.6 WTE vacancies at band 6/7. We were told that the nurse in charge role (band 7) was sometimes covered by band 6 nurses, who did not have the same level of experience.
- Recruitment was on-going and the department was working closely with the human resources department to look at ways to improve recruitment and retention. There was a rolling advertisement for band five nurses. We also heard about plans to hold an open day in early November 2016 and positions were advertised in professional journals. In order to help address the shortage of band five nurses, the emergency department had introduced a paramedic/ED practitioner role, with the first such practitioner appointed in July 2016. The trust had introduced rotational posts for registered nurses, including placements in the emergency department.
- The department was piloting the deployment of healthcare assistants to transfer patients to wards, thereby allowing registered nurses to remain in the department. Staff told us that when the transfer team was staffed, this helped to ease staffing pressures in the department. However, the department struggled to deploy staff consistently to this role. It was reported at a recent ED steering group that the fill rate for the transfer team was 40%.The trust was in the process of recruiting a pool of healthcare assistants who could be deployed flexibly and it was hoped that that the transfer team may benefit from this.
- The emergency department had developed a staffing model which aimed to provide a ratio of one registered nurse to four patients in majors. Two additional nurses, known locally as escalation nurses, were employed 24 hours a day, seven days a week to care for patients for whom there was no cubicle available. The management team confirmed that patients were frequently cared for on trolleys in the corridor or in a seated sub waiting area in majors when all cubicles were occupied by patients. This was the case at times during our visit. This situation was described as the norm and staff and managers told us that the planned staff to patient ratio could not always be maintained when the department was over capacity. One staff member told us there were, on occasions, up to 15 patients in the corridor and more in the sub waiting area, with insufficient staff to monitor them.
- Staff were encouraged to report concerns about staffing and capacity. There was a 'red flag' system which described situations considered to be unsafe

and the actions staff should take when these situations occurred. Triggers included delays in patient assessment and review, patients queuing, patients' essential needs not being met, staff not being able to take adequate rest periods and staff feeling overwhelmed, stressed or unable to cope. Staff reported their concerns to the nurse in charge, who, in turn, compiled an incident form, summarising all the red flag concerns raised on a particular shift.

- Data provided by the trust showed that 32 red flag incidents were reported in the period May to September 2016. This was fewer than had been reported in the previous four months. Nevertheless, the incidents were a cause for concern. Common concerns included skill mix, including the proportion of and quality of agency staff (with some shifts comprising between 40% and 60% agency staff), capacity in the department, leading to delayed triage, observations and medications, queuing patients and inadequate capacity to monitor those patients. On 16 September 2016 it was recorded that there was a ratio of one nurse to ten patients on the emergency department corridor.
- The nurse in charge role had been further developed since our last inspection and was key in the real time monitoring of safety in the department. They were responsible for moving staff around the department, taking into account patient numbers, acuity and dependency, and for escalating staffing concerns as they arose. They represented the emergency department at regular hospital-wide bed meetings throughout the day and night. They compiled situation reports every two hours, which provided an overview to managers of activity, performance and operational pressures in the department, including staffing. These reports were sent to the triumvirate management team every six hours.
- The situation report for 3 October 2016 showed that at 8.00 am the department was one registered nurse short for a long day shift and one short for the late shift. A message had been sent to off duty staff via social media to seek to fill these shifts and the matron had been notified. At midday it was recorded that the nurse on duty in the observation unit was not coping with paperwork but no assistance was available from ED because the department was busy. At 4.00 pm it was recorded "Struggling with staffing in ED. Escalated to matron. Unable to care for patients appropriately. Unable to meet [initial assessment] targets. Department unsafe." There was no registered mental health nurse on duty on the observation unit, requiring a registered general nurse and a healthcare assistant to be transferred from ED to assist.
- We had previously raised concerns with regard to the staffing of the children's emergency department. Following our visit in September 2015, the department received an uplift in the staff establishment. This was to ensure the department was always staffed by two nurses, one of whom was a registered children's nurse or an adult-trained nurse who had undertaken specialist training to achieve additional competencies to care for children. At the time of our last inspection in April 2016, 29% of adult-trained nurses had received this additional training.
- At our most recent inspection there were 10 WTE children's nurses in post, compared with 3.6 WTE in September 2015. The department was holding 1 WTE vacancy. Sixty-three per cent of emergency department nurses were suitably skilled to work in the children's' department. An in house 'adult to children' training course was scheduled for November 2016 and further dates were planned for 2017. In the month of September 2016, 95% of shifts were appropriately covered (57 out of 60). A red flag incident was raised on 24 September 2016 when there were two agency nurses on duty in the children's department, neither of whom had worked in ED before. At a recent visit to the ED by members of the executive management team, staff had reported staffing in the children's department was "sometimes compromised." They reported "There are not always two registered nurses and a healthcare assistant. Also on occasions there have been two agency nurses assigned to [children's ED]. Staff in [children's ED] have not always had the necessary training."
- Staff told us that at times staff continued to be moved from the children's section to the main department. It was noted at a recent ED steering group that the healthcare assistant who was deployed to monitor patients in the waiting room was sometimes deployed to do ward transfers.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

- At our previous inspections in September 2015 and April 2016 we saw limited evidence that learning took place following participation in national audits. At our most recent inspection this had improved. Outstanding actions from previous audits had been completed and we saw actions in progress from recent audits.
- At our previous inspections in September 2015 and April 2016 we reported that there was inadequate oversight and monitoring of nurse staff training. Nurse education and clinical supervision was not provided in a structured way and we could not be assured that staff had the right qualifications, skills, knowledge and experience to provide appropriate care and treatment in a safe way.
- At our most recent inspection we saw improvements had been achieved. A clinical facilitator had been appointed and there was a more structured approach to nurse training and supervision, with rostered training days each month. A training matrix provided an up-to-date overview of training completed but there was no training plan to address any gaps. We saw no evidence that this was monitored or discussed at clinical governance meetings.

Patient outcomes

- At our inspection in September 2015 we saw limited evidence that learning took place following participation in national audits. At our follow up inspection in April 2016 we found an improved picture. The trust provided us with updated action plans which demonstrated that actions were mostly complete. However a number of areas remained outstanding:
  - Mental health in ED: The action plan following the 2014/15 Royal College of Emergency Medicine (RCEM) audit recorded an action to amend the mental health assessment documentation by July 2015. This action was recorded as "in progress". A re-audit was documented as due to take place in December 2015. This re-audit took place as planned and the results were reported to the unscheduled care governance committee. The resulted showed a significant worsening of performance. Overall compliance had reduced from 60% to 42%. At our most recent inspection the clinical lead told us a re-audit was due to take place shortly, pending the imminent completion of a number of changes, which include incorporating the mental health assessment in to the electronic patient record.
  - Assessing for cognitive impairment in older people: Some actions arising from the 2014/15 RCEM audit were incomplete. At our most recent inspection we saw that all outstanding actions had been completed.
- At our most recent inspection the trust provided us with the details of recent audits:
  - Management of intoxicated patients with a head injury in the emergency department (June 2016). The trust performed poorly in this audit, with an overall compliance score of 17%. The action plan showed that junior doctors' teaching sessions had been completed. Other actions were incomplete, including a re-audit proposed for September 2016. The clinical lead confirmed that plans to re-audit in September 2016 were "over ambitious" and the audit would take place six months after the original audit, once training had been completed.
  - Vital signs in children 2015/16. The trust's performance in this audit was mixed, scoring 100% in relation to documented evidence of a senior review but performing poorly in relation to the recording of vital signs.The action plan showed that results had been discussed and shared via the clinical governance meeting and teaching sessions had taken place for junior medical staff. Action had also been taken to in relation to nursing documentation.
  - Management of sepsis. Regular audits took place in relation to screening for and treatment of sepsis. Results for the first quarter of 2016/17 were 100% for screening and 79% for treatment with antibiotics within an hour. An action plan provided evidence of work in progress to achieve full compliance.

Competent staff

- At our previous visit in September 2015 we raised concerns about the lack of oversight and

management of nurse staff training. Nurse education did not take place in a structured or consistent way and we could not be assured that nurses were able to regularly update their skills.

- In April 2016 we found that some progress had been made. A review of the training matrix had been undertaken to ensure that it was up-to-date and skills gaps were identified. There were plans to appoint a clinical facilitator to oversee nurse education and clinical supervision. We were told that oversight and monitoring of training would be reported through departmental governance meetings, with exceptions reported to divisional performance meetings. We saw no evidence that this had occurred.
- At our most recent inspection we saw that a clinical facilitator was now in post and there was a more structured approach to training and supervision. The department had begun to roster departmental training once a month. Staff attending training were also able to attend the monthly clinical governance meeting, although some staff appeared to be unaware of this. A training matrix provided an overview of staff training completed but did not provide a training plan. We noted, for example, that plans to provide training in triage were not recorded. There was no evidence in the minutes of clinical governance meetings (June, July and September 2016) that training was discussed at, or monitored by this forum.

Are urgent and emergency services well-led?

- At our inspection in September 2015 we reported that governance systems were not effectively operated. We saw limited evidence that risks identified as a result of incidents, complaints and audits were dealt with in a timely way to drive improvement.
- At our follow up visit in April 2016 we saw strengthened governance systems operated by a well informed and focussed management team. Progress against actions outlined in the trust's improvement plan was encouraging, although there was still work to do to embed changes and realise further improvements, which required time and investment.
- At our most recent inspection we saw further improvements. Governance systems had been further developed and embedded. Regular reports on performance, safety and quality ensured effective management oversight at departmental, divisional and executive levels. The local management team had taken early steps to improve staff engagement in this improvement journey, although there was still more to do. Staff awareness of risks and learning from untoward events needed to improve.
- Local management continued to be respected by staff because they were visible, accessible and supportive. The executive management team were also more visible and staff felt there was a greater understanding of the pressures they faced.
- Staff morale was improved but this continued to be significantly overshadowed by relentless demand, overcrowding, staff shortage and reliance on temporary staff. This undoubtedly affected staff recruitment and retention, which continued to be a challenge. There were a number of initiatives in place, and in the pipeline, to improve staff recruitment and retention.

Governance, risk management and quality measurement

- At our previous inspection in September 2015 we raised concerns about the effectiveness of governance arrangements in the emergency department. We judged that risks to service provision were well understood; however, the multifactorial risks to patient safety and quality were not fully captured in the service risk register or in the minutes of governance meetings. There was limited evidence that risks identified through incidents, complaints and audit were consistently used to drive improvement.
- In response to the section 29A warning notice which we issued in December 2015, the trust developed an improvement plan which outlined remedial actions to address areas of serious concern. Progress was monitored by the emergency department steering group, chaired by the chief executive. At our most recent inspection we saw that executive oversight of the improvement plan continued. The frequency of steering group meetings had been reduced to fortnightly, reflecting executive management confidence in the divisional and departmental leadership.
- Governance arrangements, which had been reviewed and strengthened at the time of our last inspection in April 2016, were well embedded. Monthly governance

meetings were well structured, with standardised agendas, including operational performance, audit, and patient feedback, including complaints, staffing and training. Minutes provided a clear and comprehensive overview of performance, quality and safety, although as noted earlier under 'Competent staff', we saw no discussion or monitoring of staff training. Our previous concerns with regard to a lack of oversight of complaints management, had been addressed and we noted there had been an improvement overall, in the response rate to complaints.

- There were opportunities for all levels of staff to attend departmental governance meetings when they were rostered to attend monthly departmental training days. This improved staff engagement and provided opportunities for learning, for example, from incidents and complaints. However, some staff seemed to be unaware of this opportunity and some staff said they did not have time to read the minutes of these meetings.
- Risks in the emergency department were captured in the unscheduled care division's risk register. Recorded risks aligned to the issues of concern raised with us by staff and managers. Risks were discussed monthly at the division's board meetings. We saw that mitigating actions were regularly reviewed at divisional and trust-wide level.
- There was a clear line of reporting from departmental, through divisional governance, to the trust's executive committee and ultimately, the trust board. There was also evidence of feedback from the executive committee to the unscheduled care division.

Leadership of service

- Following our inspection in September 2015, and in recognition of the significant management agenda, the local management team had been given some short term assistance. When we visited in April 2016 a senior matron and a programme manager had recently been appointed on secondment to support the ED matron. A new clinical lead had recently been appointed in ED and a new associate medical director in the unscheduled care division. The local management team told us they felt supported by divisional and executive management. However, staff below the management team told us the executive management team were neither visible, nor supportive within the department.
- At our most recent inspection we were advised that the matron was shortly to begin a secondment to the hospital's bed management team. It was hoped that this would improve understanding and joint working between ED and the whole site team. The senior matron's secondment, which was originally planned to finish in November 2016, had been extended to April 2017. A head of service had recently been appointed and joined the senior matron and clinical lead (consultant) to form the leadership triumvirate for ED. The team told us they felt they were now a well-established team, focussed on improvement. There had also been recent appointments of a sister, working two days a week, and an audit nurse, one day a week, both dedicated to performance improvement. The triumvirate told us they conducted a daily 'walkabout' so that they were visible and accessible to both staff and patients.
- We were told that the chief executive had recently attended a departmental meeting and had sought staff's views about the needs of the department going forward. The chief nurse had spent time in the department and the deputy chief nurse had spent a shift in the department in the coordinator role. They had fed back to the executive management team how challenging this had been. Staff and managers told us they felt there was greater understanding of the pressures they faced and that they had "a voice".

Culture within the service

- We found that staff morale had improved. Staff recognised there had been significant investment in additional staff, equipment and training. However, this continued to be overshadowed by relentless demand, overcrowding, staff shortage and reliance on temporary staff.
- Staff turnover in the emergency department was high (20%, compared with an average of 15% in the trust). The management team told us that intensity of work was undoubtedly a factor which affected retention of staff. They were taking a number of steps to address high staff turnover. These included:
  - the appointment of a clinical education facilitator in May 2016 provide training, development and supervision to staff.

- the introduction of one rostered training day a month for each member of staff. This had been in place for three months. Training topics had included: organ donation and bereavement, sepsis, non-invasive ventilation, domestic violence and multi-agency risk assessment conference (MARAC), chest pain and infection control.

- development of training pathways for nursing staff, including a career pathway for unregistered practitioners from apprentice to emergency department practitioner, and a development programme for band five nurses to support progression to bands six and seven.
- continuation of support to staff health and well-being from occupational health, staff support and organisational development teams.
- review of shift patterns currently worked within the emergency department. The management team were developing a business case regarding the staffing requirements for the department, including the review of shift patterns.
- development of internal transfers / secondment opportunities. Since July 2016, a number of internal transfers that had taken place, giving employees the opportunity to experience working in different roles across the trust. For example, a member of the emergency department had taken an opportunity to work on the SHINE project and an employee from the acute medical unit had been seconded to work in the emergency department.
- consideration of the introduction of a recruitment and retention premium.

Staff engagement

- Staff told us that they continued to feel supported by the local management team. Departmental meetings had been introduced. At the first meeting in August 2016 there was a presentation from the triumvirate leadership team, setting out their leadership vision, successes ('you said, we did'), and outlining plans for the department and opportunities for staff engagement. At the next meeting held in October 2016, the chief executive attended and shared trust-wide plans in relation to improving patient flow over the winter. There was a discussion with staff with regard to the proposed building works to improve physical capacity and a discussion about potential incentives to aid staff retention and recruitment.
- A staff forum on social media had been developed to aid communication. Members of the leadership team held drop in sessions for staff to provide feedback and make suggestions about how to improve the running of the department.

Innovation, Improvement and sustainability

- The trust had engaged management consultants to review internal systems, processes and ways of working. This included process mapping patient flow and to identify inefficiency, and bottle necks. A report was to be reviewed shortly.