

Wye Valley NHS Trust

# The County Hospital

## Inspection report

County Hospital  
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### Ratings

#### Overall rating for this service

Requires Improvement 

Are services safe?

**Requires Improvement** 

Are services effective?

**Requires Improvement** 

Are services caring?

**Good** 

Are services responsive to people's needs?

**Requires Improvement** 

Are services well-led?

**Requires Improvement** 

# Our findings

## Overall summary of services at The County Hospital

**Requires Improvement** ● → ←

The emergency department based at County Hospital, Hereford provides consultant-led emergency care and treatment 24 hours a day, seven days a week to people across Herefordshire.

The trust also provides urgent and emergency care via minor injuries units at Ross on Wye and Leominster community hospitals. However, at the time of this inspection, both minor injuries units were closed because of a system reconfiguration due to the COVID-19 pandemic.

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the emergency department service provided. Our ongoing monitoring of emergency departments raised concerns about consultant medical staffing levels and patient waiting times to assessment and treatment.

We inspected against a limited number of key lines of enquiries in the safe, responsive and well led domains. No concerns were raised on inspection that needed us to expand this inspection plan.

### **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>.

The inspection was carried out over one day by a CQC lead inspector, supported by two specialist advisors; a senior nurse with experience of emergency department care and a consultant doctor from another NHS emergency department.

We carried out the unannounced inspection from midday on a Tuesday 15 December 2020 until 9pm that evening, as this is usually a busy period for hospital emergency departments.

We spoke to hospital staff throughout the department including nurses, doctors, administrative staff and managers. We also spoke to crews from ambulance services bringing patients to the hospital. We spoke to relatively few patients because of the focus of our inspection and to minimise the infection risks from COVID-19.

We spent time observing care and speaking to staff in the department. We also observed meetings and handovers, as well as reviewing 10 sets of patient records in detail.

# Urgent and emergency services

Good   

Our rating of services stayed the same. We rated them as good.

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

We found:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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 nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, staffing was only achieved by the use of regular locum doctors.
- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

However:

- The service did not always have enough substantive staff to care for patients and keep them safe without using high numbers of bank and agency staff. Recruitment problems lead to high levels of agency staff use and some shifts not being covered and national staffing standards for children's nurses were not met.
- People could access the service when they needed it and received the right care. However, this was not always promptly as waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Performance for the four-hour target averaged 68% over the previous two weeks to our inspection.
- There was no emergency alarm for the streaming desk.

# Urgent and emergency services

## Is the service safe?

Inspected but not rated ●

We did not rate safe at this inspection.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**

The department had processes to ensure adults and children in vulnerable circumstances were safeguarded from abuse and harm. We spoke to staff about these and it was clear processes were adhered to.

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

The emergency department had a system and process for identifying and managing patients at risk from abuse. This was in line with the trust's policy for safeguarding adults and children.

There was patient information on recognising signs of specific abuse on display within the department. This included whom to contact internally and externally with concerns. We saw information in relation to female genital mutilation in line with the World Health Organisation guidelines.

Staff followed safe procedures for children attending the department. All patients under 18 were checked on the child protection register. We saw this when we looked at records for the children present in the department on the day of inspection.

On the electronic patient records, there was a detailed section of safeguarding risk assessments for both adults and children.

Staff were aware of the Mental Health Act 2005 and the holding powers that doctors, and nurses had. Staff got the advice from their mental health colleagues in the local NHS trust providing community mental health services as required. There were policies and procedures for extra observation, restraint and rapid sedation.

### Cleanliness, infection control and hygiene

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

There were sufficient quantities of personal protective equipment (PPE) available for staff to equip themselves for the different levels of protection required within the department. There were stocks of equipment available throughout the department and staff told us that this was always the case.

# Urgent and emergency services

Hand washing facilities, and where not available, sanitising gel were present in all rooms as well as corridors. Most staff carried gel dispensers on their person. We observed staff were complying with requirements for hand washing and being bare below the elbows. The trust audited compliance with these requirements and we saw copies of these audits that demonstrated that the targets were being met.

There were sufficient, labelled bins allocated for the disposal of used PPE and in all cases, these were seen not to need emptying. However, staff told us that at night emptying of the waste bins was done by nursing staff as there was no overnight housekeeping service. There were site wide “deep clean” staff available throughout the day and night to respond to requests for cubicles and treatment rooms to be cleaned after being used by patients with or suspected of having COVID-19.

We noted that staff were compliant with the required national guidance on COVID 19 precautions and wore the appropriate PPE. On some occasions we challenged staff as to their practice, but they were always able to provide an explanation as to why this was the case. For example, on one occasion we noticed that a treatment area had been labelled that PPE suitable for an aerosol generating procedure (AGP) needed to be worn before entry. We saw that while the hospital staff were wearing a suitable respirator, the paramedics handing over the patient were not. We were told that this was because the patient might need to be given airway support which was an AGP. The staff and the room were safe to do this, and the paramedics would simply leave the treatment area should that happen. (AGPs are treatments where infectious material can become airborne and require a higher level of PPE for staff including filtered respirators.)

There were reminders throughout the department to maintain social distancing and compliance with the requirement was seen to be very good. We saw that when a doctor from another part of the hospital, was not complying, their behaviour was challenged by a nurse.

We noted that the department had risk assessed staff rest areas that were used for eating and drinking and each was assigned an occupancy limit. This number was displayed on the door and there were instructions to keep the necessary two meters apart. On several occasions we entered these areas and found that staff were, without exception, adhering to the requirements. Staff working in different areas of the department were expected to keep to their own rest areas.

Staff had received training in the use of PPE and received regular updates. We asked to see training records and saw that this was the case for both substantive staff and those employed through agencies for whom the department held local training records.

Senior managers told us that they believed that no staff had caught COVID-19 at work and that there had been no transmission of the virus from staff to patients. We received information from a consultant microbiologist, that reviews of all patients who had developed COVID-19 while in hospital did not show any evidence of the infection being contracted while in the emergency department.

Equipment was cleaned between patients and labelled clean once this was done. The department had access to laboratory based and near patient COVID-19 testing.

We saw audits for cleanliness of the patient environment that demonstrated compliance with the target of greater than 95%.

## **Environment and equipment**

# Urgent and emergency services

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, there was no emergency alarm for the streaming desk.**

At the time of our inspection the department was in the process of being reconfigured. Building work was taking place and many areas, such as offices were allocated in temporary modular buildings. Because the department needed to continue to operate safely despite the work some areas were frequently reconfigured and relocated. However, there were clear plans for this, and staff spoke consistently about what was happening and what was planned.

## ***Infection Prevention and Control (IPC) Infrastructure***

There was a streaming tool in use which was aligned with the “Royal College of Emergency Medicine (RCEM) Best Practice Guideline Emergency Department IPC during the Coronavirus Pandemic”.

The department identified areas as “green” for those patients who were assessed as having a low COVID-19 positive risk and “blue” where patients were not low risk for COVID-19. Ambulatory patients were streamed on arrival to the department in line with recommended practice.

We saw building work was underway to better adapt the main entrance to support this streaming function. The streaming that was taking place was effective and safely managed. However, we noted that although there was an emergency alarm system for the reception staff there was not one for the streaming desk which was relatively isolated at the front of the building.

There was a clear system to identify “green” and “blue” COVID-19 areas and the PPE that was needed in any area was clearly communicated including where AGPs were in progress, or likely to occur. These areas were coded as “red”. There were designated areas for donning and doffing of PPE and there were separate entrances and exits to the department. There were also defined areas within the department to prevent cross contamination.

Documented processes were available for managing patients in the department to reduce the risk of cross infection which were based on risk assessments and advice from infection prevention and control leads within the trust. As well as ensuring patients were placed in suitable areas dependent on their risk of having COVID-19, other measures, such as the use of masks for patients were brought in should the department become crowded.

Due to the small size of the department, while some areas were permanently “green” or “blue” others changed according to the proportion of patients categorised as “green” or “blue” as it altered throughout the day. This was done against a written standard operating procedure. We found this system effective and intuitive.

These arrangements had been introduced on the advice of trust estates and IPC staff with reference to RCEM guidelines.

## **Mental health**

Staff carried out risk assessments for patients thought to be at risk of self-harm or suicide using a mental health triage risk assessment tool for all patients who they suspected or were known to have mental health difficulties.

When risks were identified staff had access to a psychiatric liaison service seven days a week from 8am to 6pm and 8am to 4pm at weekends. Out of hours the staff would contact the crisis team. Both teams were provided from the local NHS community trust that provided mental health services.

# Urgent and emergency services

Local NHS community trust staff who provided the mental health liaison service told us that the emergency department staff were quick to contact them. They further said that staff were good at recognising mental health concerns, good at seeking help and overall staff were “switched on”.

Asked about concerns one person told us that there were sometimes problems arranging one to one supervision for patients requiring mental health support and there was a lack of space. They also had concerns about a lack of security personnel in the department and they commented that the police would often drop people off for the department to care for. During our 2018 and 2019 inspections, some emergency department staff told us of their concerns regarding their safety, especially at nights and weekends, due to no onsite security presence. This risk had been highlighted to executives, was discussed at multiple board meetings and featured in the trust’s health, safety and wellbeing annual report 2019/20. At the December 2020 trust board, the medical division presented their quarterly report which highlighted they were worried about violence and aggression in the emergency department with 38 incidents reported during this period, an increase on the previous reporting period. An audit was being carried out on documentation from a mental health perspective to ensure that patients were receiving the correct care. Since October 2019, the trust had been working with the police and mental health colleagues to try to keep staff safe at work, this had been called Operation Nightingale. An action plan had been created including the up skilling of portering and key clinical staff in enhanced conflict resolution training as well as skills in restraint; the implementation of CCTV in the emergency department; and the roll out of body cameras within the County Hospital following the enhanced training to maximise evidence that could be used in court, as appropriate.

Prior to the department’s reconfiguration to manage the pandemic, the department had a dedicated “Woodland Privacy Room” that was built to minimise risks to people in danger of harming themselves. We found that this room was no longer available because it was used for the doffing of PPE as it had the necessary two doors.

We were told that another room had been identified and made suitable for this purpose but that because it was next to the “blue” area occupied by COVID-19 patients, staff from the organisation that provided mental health services to the trust would not use it.

We were told that different rooms were used to accommodate these vulnerable patients dependent on availability and they were cleared out and “made safe” as needed.

These arrangements were described in standard operating procedures. There was one for patients assessed as low to medium risk, where the patient would be placed in a cubicle and if they had ideated thoughts of self-harm then equipment would be removed. Consideration would be given to the provision of one to one care.

For high risk patients, similar procedures were in place, but more consideration was given to the risk of the patient absconding, as well as a higher visibility cubicle being used.

We were concerned that this approach meant that risks could not be effectively and consistently identified and mitigated, and this presented a risk to those patients who might harm themselves.

A purpose-built room was planned as part of the reconfiguration and refurbishment of the department and staff from the local NHS community trust that provided mental health services told us that they had been involved in its design.

Staff were open, candid and dissatisfied about this risk and the most senior managers were aware of it. However, when we asked whether the significance of the risk had been identified on the department’s “risk register” we were told it had not. This meant that it was not subject to the trust’s risk management arrangements.

# Urgent and emergency services

Following the inspection, the trust acted to ensure that more suitable and consistent facilities were available for patients with mental health needs by identifying a suitable specific room. We were told it would be used under a standard operating procedure to ensure patients identified as at risk received care in a safe and appropriate environment. This procedure required that identified patients were never left alone.

We also saw evidence that the risk had been placed on the departmental risk register and that trust senior leaders were aware of the risk.

## Assessing and responding to patient risk

**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.**

### Clinical Care

We saw that the guidelines and pathways for illnesses, such as diabetic ketoacidosis and sepsis, were available on the trust's intranet, were appropriate and in use. There were protocols in use for emergency situations such as trauma, cardiac arrest and massive haemorrhage which would be attended by specialist teams.

There were easy to use antibiotic guidelines and there was also a guideline for patients with suspected neutropenic sepsis.

### Initial Assessment

Patients arriving in the department on foot were first allocated to a blue stream for those with or likely to have COVID-19 and a green stream for those who were not. We spent time observing this activity which was done by an allocated "streaming nurse" and it was done appropriately using a screening tool. One of the streaming questions was whether the patient needed to be rapidly assessed and if so, this was drawn to the attention of the triage nurses and flagged up to doctors in the assessment area. Nurses allocated to the streaming desk had completed an update to ensure they had the appropriate skills.

Patients then went to a waiting area. There was a separate waiting area for areas for children which was part of the main reception but building work was underway to provide a separate children's waiting area as part of the department's reconfiguration.

Patients were then triaged to ensure that the severity of their illness was assessed, and the order of treatment decided. Nursing staff needed to complete triage training before allocated to the triage task and the department used the "Manchester" triage tool. When we observed triage taking place, we saw that it was done robustly, and full observations were taken including a pain score. There was normally one nurse carrying out triage, but another nurse was brought in as necessary to deal with any queue that built up. Triage took place under the oversight of a sister or charge nurse,

One member of staff told us they were passionate about the new triage and assessment area, that it had created more space for patients to be seen and that it was helping with flow through the department. The average time to triage in the two weeks up to the inspection was approximately 20 minutes. For the 10 patient records we sampled on the day of inspection, the average time to triage was 15 minutes. Of these 10 no patient waited more than 29 minutes and some patients were seen in less than 5 minutes.

# Urgent and emergency services

We discussed the reasons for some poor initial assessment times with the clinical lead and whether the consultant staffing levels were part of this. Senior staff agreed that this was partly so but put forward the view that there were issues with individual leadership and availability of senior staff out of hours.

## Critically ill

Seriously ill patients were pre-alerted to the department by the ambulance service and arrangements made to receive them. We saw that this was sometimes difficult where resuscitation bays were already occupied but it was done through strong teamwork including the ambulance service personnel.

There was an appropriately equipped three bedded resuscitation bay that were nominally allocated to trauma, medical and paediatric use. The paediatric bay was a separate as was possible from the other bays and had suitable equipment for children.

All pre-alerted patients, except stroke and some trauma patients, were met by staff who had already donned PPE suitable for AGP procedures so that patients who needed this level of emergency care did not have their treatment delayed while staff protected themselves.

Patients in ambulances or in the corridor, while under the immediate supervision of ambulance staff were considered as patients of the hospital and decisions about their clinical priority was made by hospital clinicians.

## Deteriorating patients in emergency department

The department used National and Paediatric Early Warning Scoring systems (NEWS and PEWS) to identify and monitor patients.

The inspection team reviewed the care plans and records for a sample of 10 patients. We found that the management of patients was generally appropriate, and no serious clinical concerns were found that needed to be raised with staff.

Several patients were waiting for beds following a decision to admit and five had been in the department for more than 12 hours. These patients were kept under observation and the scoring systems were used to monitor that they were not becoming more unwell.

The department held “NEWS Calls” which were reviews by staff of sick patients. These were attended by the medical registrar for their clinical input, so that they knew about these patients who were likely to be admitted under their care.

## Nurse staffing

**The service had nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, recruitment problems lead to high levels of agency staff use and some shifts not being covered and standards for children’s nurses were not met.**

## Workforce

# Urgent and emergency services

Nurse led care was provided by enhanced nurse practitioners who were able to work independently but were supported by senior clinicians.

We saw planned staffing levels were reviewed at bed meetings to ensure staffing levels kept patients safe. Additional nursing staff were requested when expected patient demand flagged.

Staff told us that shifts were usually filled but that there were still staffing vacancies and fill rates were only met through a high use of agency staff. We looked at records of off duty for sample days in October, November and December 2020 and we saw that this was the case.

Following the inspection, we requested rotas for the previous two weeks and saw that on most days one or more shifts for qualified staff went uncovered. This was usually only one or two shifts but occasionally three or four representing, on those occasions, 20% of the shifts being uncovered. Overall, 12% of shifts were not covered over the two-week period.

For healthcare assistants, patterns were similar, but we noted that agency staff were not used and 17% of shifts were uncovered.

Agency staff usually represented about 20% of the staff on shift. High levels of use of agency staff is usually considered to be a risk, but this was mitigated in the department because the agency staff were a stable and consistent group who worked regular shifts. This meant that managers and agency staff knew when and where they were working, and it was rare for agency staff to not have worked in the department before. We saw evidence that agency staff received a formal induction to the department and had their own training folders.

Despite this, nursing staff told us that nursing cover did not cause them concerns. One nurse said more healthcare assistants would allow nurses to concentrate on their nursing tasks rather than dealing with basic care needs. Another told us that staffing had “improved significantly over the last few months”.

Newer staff told us that there was a good training and preceptorship programme and that they felt supported. We saw evidence of this in locally held training records to which staff and their managers had access. These files were located in a resource room where staff could study with access to training materials.

The department had a lead nurse for children and a lead nurse for children’s safeguarding. Registered Children’s Nurse (RCN) staffing did not meet the standards set out by the Royal College of Paediatrics and Child Health, “Standards for children in emergency care settings” that at least two RCNs were on shift in the department. However, there was always a nurse with European Advanced Paediatric Life Support training in the department.

Children’s cover was provided with one named RCN each long day. There were two substantive RCNs employed by the department and an RCN was redeployed from the paediatric ward as needed. Each shift they were supported by a named healthcare assistant or a third-year nursing student and there was another adult nurse with paediatric competencies.

In addition to general emergency department competencies, emergency department adult nurses completed a separate portfolio of skills specific to caring for paediatric patients. This was developed and delivered by an experienced paediatric practice facilitator. The training and self-study aimed to support nursing staff in many areas, such as to be aware of their own skills and development needs; to recognise children who were sick or at risk of deterioration; to understand the differences in anatomy and physiology at different ages; and to understand common childhood illnesses and their treatment.

# Urgent and emergency services

The paediatric practice facilitator would work supernumerary one to two days a week in the emergency department, they would work with nurses looking after children and provide support, training and further learning opportunities in practice.

Following the inspection, we requested rotas for the previous two weeks and saw that this staffing requirement was always met.

At night children's cover was provided by adult nurses with additional, competency assessed training which included level three safeguarding and Paediatric Intermediate Life Support.

## 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, staffing was only achieved by the use of regular locum doctors**

## Workforce

Consultant led care was provided with two consultants working overlapping shifts in the department from 8am to 7pm supported by a team of junior doctors. Middle grade doctors worked on overlapping shifts as did the foundation year doctors in the department.

The department had been operating with a low number of employed consultants for some time and relied greatly on locum staffing. In total there were three point six five (3.65) whole time equivalent consultant doctors. Two were full time, one was an NHS locum and the difference made up from locum staff.

There were two emergency department consultants on duty each day providing consultant cover from 8am to 7pm. One shift was from 8am to 4pm and the other from 11am to 7pm. Outside these hours an identified consultant was available by telephone or to come in if required. Consultants worked a one in four on-call rota and gaps were covered by locums.

There were 15 middle grade positions but only 10 were filled with the gaps taken up by locum staff. All the 15, foundation year two posts were filled.

We reviewed the staffing records for a sample of days, including weekends, in November and December 2020. Although occasional gaps were seen, these were only one, or occasionally two shifts not covered in a 24-hour period. Following the inspection, we requested medical staffing rotas for the previous two weeks and these demonstrated that there were only occasional times when shifts were not covered. In the two-week period one consultant shift was not covered out of 48; three middle grade shifts were not covered out of 94; and six foundation year doctor shifts were not covered out of 118.

We spoke to a registrar and a foundation year doctor who both confirmed that they had regular programmed time for teaching and training and had received induction when they started in the department. They were satisfied with the way that rotas were managed and they both told us that they had access to senior staff when they needed advice including out of hours.

# Urgent and emergency services

There was a paediatric consultant available 24 hours a day, seven days a week. They supported the team with children who were acutely unwell. The clinical lead also had a specialist interest in paediatrics. There was not a dedicated paediatric emergency medicine consultant in the department.

The trust recognised medical staffing and recruitment as concerns, and they were graded as a “moderate” risk on the risk register. This noted that the medical staffing and the training and development model had been restructured to make the department more attractive to recruits. The medical staffing department was carrying out active recruitment and there were new staff “in the pipeline”.

## Is the service responsive?

Inspected but not rated



We did not rate responsive at this inspection.

### Access and flow

**People could access the service when they needed it and received the right care. However, this was not always promptly as waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Performance for the four-hour target averaged 68% over the previous two weeks to our inspection.**

#### Flow

Information was available to staff on the status of patients and on the performance of the department through the trust’s electronic patient record system. The inspection team requested information throughout the day and staff were able to make use of the system to quickly report on the situation at any time.

We observed that staff recognised when the department was coming under pressure and were proactive in decanting patients to other areas to keep all patients safe.

There were standard operating procedures in place to allow patients to be cared for in ambulances or in extremis in the corridor should the emergency department capacity be exceeded. These procedures identified how and who should make decisions and how the situation should be escalated. Patients in ambulances or in the corridor, while under the immediate supervision of ambulance staff were considered as patients of the hospital and decisions about their clinical priority was made by hospital clinicians.

During our inspection, there was a situation that meant patients were unable to be sent to a ward as planned because of an emergency that was taking place on the ward. This required that for a short time two patients needed to be cared for in an ambulance. We observed that these patients were assessed and decisions about what to do were made through discussion in a “huddle” by senior staff and that the ambulance crews were also involved in the decision making.

### 12 hour waits and performance

# Urgent and emergency services

As we monitored patient stay, we noted for most of the day there were five patients who had been in the department for more than 12 hours. One of these patients spent 19 hours in the department as they were waiting for a side-room to be available for them. There was a room for them to go to, but they were waiting for it to become available. While this was undesirable senior staff were always aware of each patient's situation and their condition was monitored.

Figures provided by the trust showed that patients frequently spent more than 12 hours in the department and one or more patients waited 24 hours for admission on most days in the two weeks leading up to the inspection. Figures for the previous two weeks showed that on half the days more than 20 patients spent over 12 hours in the department.

Figures for the previous two weeks showed that performance against the four-hour target averaged 68%. Except for one day when attendances were almost 25% higher than the average for the period, ambulance handover delays of more than 60 minutes took place, on half of the days and involved one or two patients.

Observations and review of patient's notes indicated that patients' needs were identified, and patients received the care they needed which was prioritised on their clinical condition.

We were told by ambulance staff that queuing in corridors "used to be the norm" but that this had reduced following changes to the department.

There was a hospital ambulance liaison officer present at busy times to liaise with the department and would be available to oversee any patients in the corridor to release ambulances back onto the road. During our inspection, there were no patients receiving corridor care other than those waiting a short time to be handed over.

Although we did not observe it, we were told that at 9pm each day there was a paediatric huddle with the paediatric team discussing each child in the department and the plan for each. This made an effective process for allocating beds early on the paediatric ward if patients needed admission. During the day if a child was deemed as low risk, they would be taken to the paediatric ward to be seen.

## **Bed and flow meetings**

Cross trust bed meetings, also known as flow meetings, took place at 8:30am, midday and 4pm each day. We were told that additional meetings were slotted in at 2pm and 5pm as needed.

We joined the emergency department team for a 2pm bed meeting which took place as a teleconference. Appropriately senior staff were present, and the meeting was organised and well chaired.

At the time of our inspection, the department and the hospital were experiencing stress from the number of patients attending. The meeting noted that the emergency department's major's area was full, and that the department was "just coping". Because it was expected that the department would reach capacity later in the day, staff were reminded of the standard operating procedure to enable patients to be cared for the corridor or waiting ambulances.

The planned staffing level for the nightshift was in place but because of the expected demand the status was flagged as "amber" and two additional members of nursing staff were requested.

# Urgent and emergency services

There was an electronic tracking system in use and information requested by the inspection team throughout the day was readily available. We were told that as wards were moving to use this system through digital whiteboards the system was becoming more effective. Through this staff could identify where patients were and their status throughout the hospital.

In respect of the emergency department at the 2pm bed meeting the trust were predicting 37 admissions for the 24hour period 12 patients had been admitted since 0830hrs and were 12 patients awaiting an inpatient bed of which 5 had been allocated a bed. As a result of the pressure, an action was noted to challenge whether every patient across the hospital needed to be there and to address any barriers to discharge by escalation to senior staff if necessary. Some community beds were available for use, but it was noted that there were problems getting patients out of those beds and this was escalated to the local clinical commissioning group.

We were told about the software used to track flow and how it had the facility to predict demand from past data. This was to some extent compromised by the unique situation of the pandemic, but staff were able to discuss how external factors might affect arrival rates at the emergency department and how this was used in their planning. We saw that reoccurring patterns of attendance occurred on daily or weekly cycles.

We asked staff about barriers to patients leaving the department and were told that during the pandemic there had been some decrease in access to senior staff and decision making. However, overall, no-one was blocking or stopping discharge or admission in the ways they were before the pandemic and whilst staff were still appropriately challenged, they were actually able to do more to facilitate patient flow.

## Is the service well-led?

Inspected but not rated ●

We did not rate well-led at this inspection.

### Leadership

**Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

During the inspection, it was noted that leadership appeared strong at all levels in the department. We saw that staff respected the leaders and this was reciprocated with senior staff speaking, and acting, in a way to get the best out of people. Leaders were visible in the department.

Staff took charge of and responsibility for issues that arose during the day and it was common to see staff gather together in “huddles” to discuss what to do and develop a plan.

Staff gave a consistent and positive view of the leadership in the department. Comments included “overall a very good department”; “management approachable and helpful”; “management really strong but approachable” and “recent changes were all for the better”.

One relatively junior member of staff mentioned that this positive leadership extended to “including gold command”.

# Urgent and emergency services

Asked about any recent changes a senior leader told us that in the past there had simply been too much change going on. The department now had a sound strategy for the future and was in the process of reconfiguration with building work and temporary arrangements to accommodate that while we were there. That this coincided with the pandemic created problems but there was no choice other than to continue.

The most senior managers in the department appeared to work well together and presented a common and consistent view as to the department's way forward. We were told that the executive team now let them get on with what needed to be done while still maintaining sufficient oversight and challenge.

## Culture

### *Culture (including staff wellbeing)*

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.**

Although under pressure, staff appeared relaxed and confident in the presence of the inspection team. While they largely spoke positively about the department, they did raise issues that concerned them and were not afraid to do this in front of other staff, indeed they would sometimes draw senior staff into such a discussion with the inspection team.

Many staff spoke with evident pride about the department and went out of their way to tell us that they were happy and proud to work there. This continued to be the case when we gave staff the opportunity and encouragement to speak in a private setting.

We observed that staff worked and communicated well as a team, both within and across professional groups. When an issue needed to be discussed it was common for a small group of staff to be gathered together to come to a decision as to what to do. It was notable that these discussions were calm, respectful and that staff were actively listening to each other without interrupting or raising voices.

One nurse told us that relationships between medical and nursing staff were "excellent, and that there were "clear communications". A doctor who had worked in the department for some years agreed that there was good teamwork, communication and support from senior staff. They told us that they would recommend the department as a place to work as did a more junior doctor to whom we spoke.

Paramedics from the ambulance service told us that they had good relationships with the department. We were told that staff were approachable and that they felt confident in escalating if a patient was unwell. The ambulance service deployed a hospital ambulance liaison officer during busy times, and they were involved in hospital meetings to ensure good communications between the organisations. The site manager for the private ambulance service who provided patient transport service attended bed meetings and hospital staff told us this improved flow by getting patients out of the department to home or another care setting.

We saw the most recent staff wellbeing survey and it did not raise any areas of significant concern.

## Management of risk, issues and performance

**Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

# Urgent and emergency services

We spoke to senior staff about the way that significant risks were managed in the department. They showed us that this was done using a risk register which was overseen at an executive level through the trust's board assurance framework.

We asked which were the most significant current risks in the department and we were told that they were staffing and overcrowding. There had been a problem with recruitment and retention of medical staff for some time and the situation was still difficult with half of the consultant level staff and one third of the middle grade doctors being locums. However, there were many more junior staff now in substantive posts, shifts were well covered, and it had been the intent to solve this problem before moving on to addressing the consultant posts. We saw that there was a business case in progress to address consultant recruitment.

Following the inspection, we requested a copy of the department's risk register and we saw that it described these risks together with plans, mitigation and any gaps in assurance. The information in the risk register was consistent with that which we discussed with senior staff.

## Areas for improvement

We told the trust that it should take action either because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall. These actions related to the emergency department.

- The trust should ensure that it continues to pursue recruitment initiatives to establish substantive medical and nursing staff employed by the trust (Regulation 18).
- The trust should ensure that it continues to strive to meet the national standards for Registered Children's Nurses and a paediatric emergency medicine consultant in the emergency department (Regulation 18).
- The provider should ensure urgent and emergency services meet the national standard patient waiting times for treatment and arrangements to admit, treat and discharge patients (Regulation 12).
- The trust should ensure improved security provisions within the emergency department to ensure staff feel safe at work (Regulation 17).
- The trust should consider the installation of an alarm facility on the streaming desk.

# Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisors. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.