James Paget University Hospitals NHS Foundation Trust

James Paget Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at James Paget Hospital

Inspected but not rated

James Paget University Hospital provides care to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia. The trust's main site in Gorleston is supported by the Newberry Clinic and other outreach clinics in the local area. The trust employs over 3,000 staff, both part and full time, making them the largest local employer in the area.

We carried out an unannounced focused inspection of James Paget University Hospital urgent and emergency service (also known as accident and emergency – A&E) and medical care services (including older people's care), on 15 and 22 February 2022. We also had an additional focus on the urgent and emergency care pathways across Norfolk and Waveney and carried out a number of inspections of services in a few weeks. This was to assess how patient risks were being managed across the health and social care services during increased and extreme capacity pressures.

As this was a focused inspection at James Paget University Hospital, we only inspected parts of our five key questions. For both core services we inspected parts of safe, responsive, caring and well-led. We included parts of effective in medical care. We did not inspect effective in urgent and emergency care at this visit, but we would have reported any areas of concern.

The emergency department was previously rated as good overall and good for all key questions. Medical care was previously rated as good overall with safe rated as requires improvement.

For this inspection we considered information and data on performance for the emergency department and medical care. This inspection was partly undertaken due to the concerns this raised over how the organisation was responding to patient need and risk in the emergency department and the wider trust in times of high demand and pressure on capacity. We were concerned with the waiting times for patients, delays in their onward care, treatment and delayed discharges, as well as delayed and lengthy turnaround times for ambulance crews.

We looked at the experience of patients using the urgent and emergency care and medical care services in James Paget University Hospital. This included the emergency department, medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We also visited wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

A summary of CQC findings on urgent and emergency care services in Norfolk and Waveney.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Norfolk and Waveney below:

Norfolk and Waveney

Our findings

Provision of urgent and emergency care in Norfolk and Waveney was supported by services, stakeholders, commissioners and the local authority. The health and care system in this area lies across a large, predominantly rural, geographical area with a large proportion of the population aged over 65 years.

Compliance with CQC regulations has historically been challenging across Norfolk and Waveney, particularly in Acute, Mental Health and Adult Social Care services, many of which have been rated Requires Improvement or Inadequate.

We spoke to staff in services across primary care, urgent care, acute, ambulance services, mental health and adult social care. Staff told us of increased pressure across urgent and emergency care pathways, staffing issues and a lack of capacity in key sectors including GP and Dental practices and social care. These issues were resulting in inappropriate calls to 999 and attendances in emergency departments. There were delays in discharge for patients who were medically fit but unable to access appropriate packages of care to enable them to leave hospital.

We previously inspected mental health services in the Norfolk and Waveney area in November and December 2021 and found, due to an increase in referrals and staffing shortages, patients in the community had long waits to be seen. This led, in some cases, to patients deteriorating and requiring urgent and emergency treatment. In addition to this, some inpatient services (such as CAMHS) did not have available beds within the area. Patients were kept in urgent and emergency care settings whilst a bed was found. During inspections of acute services, we found patients unable to access appropriate and timely care to meet their mental health needs.

We inspected a number of GP practices and found some concerns in relation to access for patients trying to see or speak to their GP. We found high levels of staff absence resulting in some staff working long hours and experiencing increased pressure on their services.

To try and alleviate the increasing demand on Emergency Departments, GP streaming services had been introduced in EDs in Norfolk and Waveney. Patients who presented at the ED with problems which were deemed suitable for a primary care appointment could be referred to a co-located primary care service. In some cases, streaming services helped to prevent up to 33% of patients attending the ED.

We inspected urgent care services in the Norfolk and Waveney area and found these to be well-run. However, an on-going shortage of out of hours and urgent care appointments, particularly for urgent dental care, meant patients couldn't always be appropriately signposted by NHS111. This meant patients often presented to ED for treatment. NHS111 in Norfolk and Waveney had also experienced significant staff shortages, much of which has been due to the COVID-19 pandemic. Leaders in this service had a recovery plan in place; however, staff shortages and increased demand had resulted in significant delays in call answering and call-back times in comparison to the national targets and there was also a very high call abandonment rate, meaning people ended the call before speaking to an advisor. Whilst performance across Norfolk and Waveney did not meet national targets and people experienced significant delays, these delays were, on average, shorter than regional and national averages

We inspected emergency departments (ED) in Norfolk and Waveney between December 2021 and February 2022 and found lengthy delays for people accessing emergency care. A high number of patients were waiting over 12 hours in ED resulting in overcrowding. This impacted on ambulance handovers and further delays in releasing ambulance crews into the community to respond to 999 calls.

Staff shortages have had a significant impact on social care services across Norfolk and Waveney. In addition, the provision of domiciliary care services is challenging due to the rurality of the area. At the time of our inspections, a care hotel was being utilised in Norfolk and Waveney. We spoke to healthcare professionals who had provided services to

people being cared for at the hotel and found them to be safe and generally well cared for. The number of people receiving care in the hotel was small and the aim was for them to only stay for a very short amount of time before going home. This service is commissioned until the 30 April 2022, a formal evaluation will take place before any future plans are agreed.

Some social care and learning disability services in Norfolk and Waveney have struggled to achieve compliance with CQC regulations and a rating of good. Some support has been established across Norfolk and Waveney to help services improve. However, the impact of any support to date has been limited.

Staff shortages and service quality has significantly reduced capacity across social care and learning disability services in Norfolk and Waveney. This has resulted in significant delays in transferring people from hospital to their own home or an appropriate place of care. This in turn meant people who were medically fit for discharge remained in hospital delaying the admission of new patients. These delays and poor flow resulted in overcrowded EDs and an inability to transfer patients from ambulances.

Strategic, system wide workforce planning and increased community provision of health and social care is needed to meet the needs of the local population. This is needed to reduce the pressure on urgent and emergency care services and to reduce the risk of harm to people living in Norfolk and Waveney.

Summary of James Paget University Hospitals NHS Foundation Trust – James Paget University Hospital

We inspected this service but did not rate it:

Services had enough staff to care for patients and keep them safe and they service controlled infection risk well. Staff managed medicines 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.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

The trust planned care to meet the needs of local people and engaged well with other health care providers and system partners to plan and manage services.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. Staff felt respected, supported and valued.

Leaders ran services well using reliable information systems. They were focused on the needs of patients receiving care.

However:

Patients could not always access treatment in a timely way. The trust's median total time in ED for those patients who had a decision to admit (DTA) was considerably longer than the England average. As of December 2021, the trust median was seven hours 45 minutes. The England average was five hours 24 minutes. The trust reported the highest number of patients waiting over 12 hours from the decision to admit to admission in the East of England region in June 2021.

Our findings

Between October 2021 and December 2021, 18.5% of ambulance handovers took more than 60 minutes, this was mainly higher than the regional and England averages.

Paper based nursing care records were not always complete and all staff could not always access all the relevant information easily. Numerous computer log ins and computer systems which did not interface created risks of lost information, and delays in staff accessing the appropriate information.

How we carried out the inspection

During our inspection we spoke with 44 staff members including registered nurses (RN), medical staff, clinical support assistants (CSA), two paramedics, one hospital ambulance liaison officer (HALO), the chief operating officer and the divisional operational lead.

We observed care provided and spoke with 11 patients. We reviewed 20 patient nursing and medical care records.; attended site meetings, reviewed relevant policies and documents and reviewed ten patient records.

After the inspection we carried out a telephone interview with the four urgent and emergency medicine service leaders.

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

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

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.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. In all areas we visited, the floors, walls, curtains, trolleys and areas in general were visibly clean. All patients reported wards being clean.

The service performed well for cleanliness. There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Environmental audits were completed monthly and compliance exceeded 97% across all medical wards in the last three months, from November 2021 – January 22. Cleaning audits supplied by the trusts after the inspection showed compliance was above 97% for November 2021, December 2021 and January 2022. This exceeded the trust target of 95%.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had enough PPE and staff followed the trusts policy when supporting patients, including wearing masks, aprons, gloves and face shields / goggles where necessary. Hand sanitiser and washing facilities were available on all wards, signage advised staff and visitors to follow infection control practices, when entering and leaving ward areas.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Staff used the call bell system and ensured that patients had these within reach when necessary.

The design of the environment followed national guidance. All wards we visited had separate male and female bays, with separate toilet and washing facilities allocated to each bay. Security staff protected vulnerable patients from leaving the building. Staff gained access to wards and clinical areas with electronic cards. Visitors accessed the ward using a call bell, which enabled staff to monitor visitors and patients entering the wards. Wards had facilities to isolate patients and staff closed doors to treat patients who were at risk of infection.

Piped oxygen and suction equipment was available at each bed space, as well as emergency call buttons.

Staff carried out daily safety checks of specialist equipment. Staff completed daily safety checks of specialist equipment such as resuscitation trolleys and medicines fridges. Staff locked and secured resuscitation trolleys with tamper seals.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients and staff we spoke with did not report any shortages of equipment. We saw equipment used to safely lift patients displayed the date of the last and next service displayed and these were in date.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps. Sharps bins seen were appropriately labelled and stored correctly.

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used in the service to identify patients at risk of deterioration. NEWS2 is a point system tool used to standardise the approach to detecting deterioration in a patient's clinical condition. The NEWS2 was calculated and recorded on a paper-based system. The generated NEWS2 score provided a prompt to the staff entering the data, to review if the patient was unwell and/or deteriorating and required a medical review. We reviewed eight number of patients records and saw that scores were completed correctly. When a concerning score had been calculated the patient was escalated for medical review in line with the trust policy.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed eight patient records and saw risk assessments were completed on admission and reviewed in line with the trust policy. The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Data provided by the trust following our inspection showed the average compliance with completing VTE risk assessments within medicine from October 21 to January 21 was 97.3%. All the records we reviewed during our inspection had the relevant VTE risk assessments completed.

Staff knew about and dealt with any specific risk issues. The trust had processes in place to ensure patients received specialist care when required. If patients scored more than five on their NEWS, then their care was appropriately escalated, and we observed this within patient care records.

There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening illness when the body's response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff were able to describe the signs and what treatment should be initiated in line with national and local guidance. This included completing the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients.

Medical care (including older people's care)

Staff had access to onsite critical care for patients who required additional one to one care for invasive intensive interventions

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the mental health team should they have any concerns, and there was a timely response to assess patients.

Nurse staffing

The service mostly had enough 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 mostly had enough nursing and support staff to keep patients safe however the planned numbers did not always meet the actual numbers of staff. On the day of our inspection, the actual nurse staffing did not meet planned nurse staffing level - the frailty unit and on EADU had the number of staff registered nurses and health care assistants as planned. The stroke ward, the hyper acute stroke unit, and ambulatory care were all had one registered nurse less than planned.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing requirements were discussed with the wider management team throughout the day at site meetings. We saw matrons working with senior sisters to coordinate staffing levels to help support areas with lower staffing/higher patient acuity.

Data submitted by the trust states that nursing staff across medicine were currently over established by 15%. However, some of these staff were internationally recruited and were in the process of being inducted into their roles.

The trust used bank nurses to ensure staff familiar with trust policies and procedures were employed where possible and most wards were required to use bank and agency staff.

The trust had an annual sickness rate of 5.10% for nursing staff and 8.65% for nursing support staff as at 31 January 2021. The trust had an action plan to enable staff on long term sick to return to work. The trust had set a target of 3.5% however this was under review due to the pandemic.

The trust had an annual turnover rate of 9.94% against a target of 10% for nursing staff and 3.19 % for nursing support staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used a safer staffing tool to monitor staffing levels and ensured that staff were delegated appropriately across the service. Regular meetings throughout the day enabled the staff team to identify any areas where staffing shortfalls occurred.

The ward manager could adjust staffing levels daily according to the needs of patients. We saw matrons speaking with ward managers to make sure that staffing was appropriately allocated where there was higher acuity patients.

Medical staffing

Medical care (including older people's care)

The service usually 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.

Staff told us they had enough medical staff to keep patients safe however on the day of the inspection we were told that the medicine division which included the emergency department was down 13 doctors, two consultants and 11 junior doctors and this was one of the factors contributing to the trust declaring an OPEL 4.

The service had low vacancy rates for medical staff. Data supplied from the trust showed that the medicine division was under established by 0.74% at January 2022. There was a total of 43.03 WTE consultants within medicine. At the time of the inspection the trust was planning to increase establishment and recruit to 8.85 WTE establishment vacancies.

The service had turnover rates for medical staff of 11.74% for the past 12 months.

Sickness rates for medical staff were low. Data submitted following our inspection showed that sickness rates were 1.99% for the twelve months up to January 2022.

The service had low rates of bank and locum staff. According to data submitted by the trust bank and agency staff covered 6.21% of hours for medical staff.

Managers made sure locums had a full induction to the service before they started work. Staff we spoke with said that locums received a full induction in line with the trust policy. Ward managers used a bank of agency staff that were familiar with the service so that staff who knew the service were used.

Within the acute cardiac unit consultants were available five days a week and were available remotely out of hours.

Is the service effective?

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. During 2020/21 the trust completed 41 national clinical audits and 100% of national clinical audits it was eligible to participate in.

There was an annual audit plan which enabled the service to benchmark the standard of care against local and national standards.

Medical care (including older people's care)

The service participated in relevant national clinical audits. Examples included, but were not limited to, national cardiac arrest audit, and national diabetes audit. Performance in national outcome audits were variable. However, appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required. For example, we saw evidence of action plans following audit results to improve patient outcomes.

Outcomes for patients were generally positive, consistent and met expectations, such as national standards for example recent Sentinel Stroke National Audit Programme (SSNAP) performance was rated B.

Managers and staff used the results to improve patients' outcomes. Staff were aware of audit results and were able to reflect on things that had gone well and that needed to be improved. We saw the specialties discussed audit results as part of their local governance and had action plans to address any developments.

Managers used information from the audits to improve care and treatment. We saw governance papers that showed action plans to improve performance against national audits and that these were reported to the trust board.

Managers shared and made sure staff understood information from the audits. Staff we spoke with were knowledgeable of relevant national audits and were able to talk about how their work contributed towards a culture of improvement.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Senior staff held regular bed management meetings at 9am, 11.30am, 2pm and 4pm to discuss key issues relating to patient care and patient flow.

Each ward had a daily multidisciplinary discussion about the patients in their area – this included patients' diagnosis, treatment plans, concerns and any discharge planning.

Staff referred patients for mental health assessments when they showed signs of mental ill health and or depression. Staff we spoke with during our inspection were aware of the mental health liaison teams and provided examples of cases where they referred patients to the service.

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Patients had their care pathway reviewed by relevant consultants. In the records that we reviewed we found patients had a prompt consultant review on admission and throughout their stay on daily ward rounds.

Seven-day services

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

Medical care (including older people's care)

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. We were told that there was a medical on call team including senior medical staff, which was available on weekdays, and on call out of hours and weekends.

On the stroke unit telemedicine was in place so that patients could be reviewed out of hours, additionally consultants could access patient scans remotely out of hours.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection, on all wards we witnessed staff interacting positively with patients.

On the stroke ward there was an audible monitor that was positioned in between the nurses' station and the patient bays. This was used to remind staff to keep noise to a minimum.

Patients said staff treated them well and were very caring.

We observed staff interact with patients living with dementia in a calm and caring manner.

Staff followed policy to keep patient care and treatment confidential. We saw that when a patient was being examined, the curtains were drawn around the patient to maintain privacy and the dignity of the patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients were able to book appointments to see family and loved ones on the hand held video devices, this enabled visitors to see patients who may otherwise not be able to travel.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw in patient records that staff had spoken with patients and/or their families/ carers to provide information relating to their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff said they had access to communication aids and these were used to help explain care to patients who may have difficulties with expressing how they were feeling or were living with dementia.

Medical care (including older people's care)

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patients we spoke with felt confident to raise concerns with staff and there was information displayed on the wards that outlined the process for providing patient feedback.

Patients gave positive feedback about the service. We saw patient feedback boxes on ward, with comment cards available for patients, families or visitors to provide feedback

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The frailty service aimed to identify patients with frailty as soon as possible, to improve outcomes, including reducing avoidable hospital admissions and supporting patients to be cared for in the community.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were familiar with the importance of same sex accommodation. We saw evidence of single sex bays, toilets and shower facilities all most wards.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a variety of specialists including specialist nurses who were available for offer advice and support to staff and patients. For example, the service had access to a tissue viability service to help patients developing or at risk from developing a pressure ulcer.

Managers monitored and took action to minimise missed appointments. We saw that managers took steps to ensure that elective procedures were maintained at a time when the hospital was a capacity and there was consideration to cancel appointments.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment were not always in line with national standards.

Managers monitored waiting times however, patients could not always access services when needed and did not always receive treatment within agreed timeframes and national targets. The trust was operating at capacity. They had 84

restricted beds which were occupied and 13 beds that were unoccupied that could not be used to admit patients, across the hospital due to infection prevention and control issues such as COVID-19 positive patients requiring isolation. The trust had 99 patients medically fit for discharge however were awaiting coordination from partnering agencies to provide appropriate care packages. As patients were unable to leave the hospital this impacted on medical specialities to free up capacity and flow through the medical division.

The trust did not meet national standards for 62 day wait for first treatment. Data from April 2021 to January 2022, showed that 70.53% of patients received treatment from an urgent GP referral for suspected cancer against the target of 85%. The trust also did not meet the 90% target for treating patients referred from the NHS cancer screening service referral as the trust rate for 2020/21 was 80.12%

The NHS Constitution states that 'no-one should expect to wait more than 18 weeks from the time they are referred to the start of their consultant-led treatment, unless it is clinically appropriate to do so or they choose to wait longer'. The trust performance was 95.5% for referral to treatment, on completed pathways in Medicine, within 18 weeks for November 2021 and this was against a national average of 78.8% and exceeded the national standard of 92%.

Managers and staff worked to make sure patients did not stay longer than they needed to. There were daily meetings where access and flow was discussed at a ward level. On the days of the inspection 99 patients were ready to discharge however 66 patients were waiting on external agencies to coordinate packages of care prior to discharge. Ward managers and discharge coordinators worked to move patients to discharge once care had been coordinated with community support services.

The service moved patients only when there was a clear medical reason or in their best interest. The trust worked to keep ward moves to a minimum and where there was a medical need.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service leads we spoke with said that executives were visible and approachable in the department and that they could raise concerns without fear. All staff that we spoke with said they were able to raise concerns with local managers.

There was an established leadership structure within the medical division. This included a divisional director of operations, assistant medical director and a lead nurse. They were supported by clinical directors, matrons and ward managers. Staff we spoke with told us the management team were supportive and visible within the wards.

Senior leaders had a thorough understanding of the improvements that were needed to strengthen the quality of their service. They understood the challenges to quality and sustainability the medical care service faced and had pro-active ongoing action plans in place to address them.

Medical care (including older people's care)

At local level matrons oversaw multiple wards and assisted ward managers. We observed matrons were visible on the wards. Ward managers said they were supported by the matrons and senior leads. Ward managers were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward's performance against the trust priorities and the areas for improvement.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service regularly reviewed its mortality outcomes and had encouraged junior doctors to share learning from errors identified in clinical mortality review group meetings.

The governance framework in medical services ensured staff responsibilities were clear and quality and performance risks were understood and managed. Senior staff understood their roles in relation to governance and their level of accountability with regard to providing a safe service to patients and their families.

Leaders were forming a business case to recruit enough staff to provide a seven day service, working towards ensuring patients have a consultant review every day in all specialities.

Staff were able to describe the governance structure across all levels of the service and believed communication, on the whole was good. There were systems to review the National Institute for Health and Care Excellence (NICE) guidelines and other nationally recognised guidance.

The trust Patient Flow and escalation policy set out how leaders and staff should operate to support and deliver optimum patient flow. The policy is aligned to the National Operational Pressures Escalation Levels Framework (OPEL). The policy sets out how roles and responsibilities for leaders and ward staff. On the inspection all staff were aware that the trust had announced OPEL 4 – critical pressure status and their role in ensuring that patient flow was maintained.

Areas for improvement

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

Medical care

The trust should ensure people can access services when they need it (Regulation 12).

Urgent and emergency services

Inspected but not rated

Is the service safe?

Inspected but not rated

Safeguarding

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

The trust had a safeguarding policy which detailed the contact details for the named nurse for safeguarding children and the lead for safeguarding adults. The policy described the identification and management of patients at risk of abuse including domestic violence and female genital mutilation (FGM). The policy was in date and version controlled and referenced up to date national guidelines.

Nursing staff received training specific for their role on how to recognise and report abuse. Data supplied by the trust after the inspection showed nursing staff were over 95% compliant with mandatory safeguarding adults level 3 and safeguarding children level 3 training. This met the trust wide target.

Data supplied by the trust after the inspection showed 90% of medical staff had completed mandatory safeguarding adults and children level 3 training. This met the trust target of 90%.

Since 2020 mandatory safeguarding had been delivered on-line but the trust planned to return to face-to-face teaching.

Staff followed safe procedures for children visiting the ward. Staff observed children in the self-contained paediatric waiting area via CCTV.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had displayed posters throughout clinical areas to act as memory aids when making safeguarding referrals.

Staff completed assessments for those patients who were identified as being at risk of self harm and had a policy describing enhanced observations.

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.

In response to the pandemic, the trust had re-configured the ED and implemented ‘Red’ and ‘Amber’ areas within the ED to maintain patient and staff safety. Red areas were designated as high risk COVID-19 areas. Amber areas were designated as safe areas for patients not showing symptoms of COVID-19 and those with negative COVID-19 test results.

Staff used rapid testing for COVID-19. Staff tested patients who may need to be admitted to the ED to establish their COVID-19 status in the waiting room before admission to the ED. This ensured patients were directed to the appropriate COVID-19 area in order to minimise the risk of the spread of infection.

All areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly Cleaning audits supplied by the trusts after the inspection showed compliance was above 97% for November 2021, December 2021 and January 2022. This exceeded the trust target of 95%.

The service monitored cleaning audit out comes on a monthly basis using an electronic tool. This was an improvement on our last inspection (December 2019) where the service did not have oversight of cleaning outcomes.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff changed PPE between each care episode and between patients.

Two staff members described how patients who self-presented to the ED, and believed they were COVID-19 positive, used a yellow telephone outside the ED to alert medical staff they were present. Nursing staff would don the appropriate personal protective equipment (PPE) and go out to meet the patient.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, staff did not always have enough appropriate equipment.

IPC infrastructure

The ED comprised of several areas, reception and waiting room, triage, four adult resuscitation cubicles (resus), seven minors cubicles, five see and treat cubicles, 14 majors rooms, three trolley bay ambulance cohort area, paediatric resus room, one secure ligature free mental health room and a five room decision to admit (DTA) area.

Adult resus cubicles were separated by solid divides with doors and not curtains, this meant they were safe to carry out aerosol generating procedures (AGPs) for patients who were COVID-19 positive as well as those who were COVID-19 amber. AGPs are treatments where infectious material can become airborne and requires a higher level of infection control.

The 14 individual majors rooms had glass doors with built in privacy screens. This meant patients could be cared for in isolation but staff could still see them in order to keep them safe. Two of the rooms were negative pressure. A negative pressure isolation room is commonly used for patients with airborne infections. At the time of our inspection three rooms were being used for patients who were COVID-19 positive. The service could flex the number of COVID-19 positive rooms up and down in line with demand due to all the rooms having the ability to provide isolation.

The ambulance cohort area had space for three trolleys. This meant ambulance crews could unload patients into a safe space and be available to return the ambulance to service quickly.

Urgent and emergency services

The paediatric area consisted of a triage room, resus room, four minors cubicles and a separate enclosed and secure waiting area.

The paediatric resus room was fully equipped for resuscitation of children with all sizes of equipment. Records showed staff completed daily checks to ensure equipment was present and appropriate. This was an improvement from our last inspection (December 2019) where staff had not completed equipment checks in line with trust policy.

The service had introduced social distancing in the waiting area and staff guided patients to seats to ensure this was adhered to.

The design of the environment followed national guidance. The trust had audio and visual separation of the paediatric waiting area from the adult waiting area which was accessed by swipe card only.

The trust had a designated room which was safe for patients attending the department with mental health crisis to use. Staff told us this was a protected space even when the department was busy. The room was ligature point free and had an accessible alarm system.

The service had suitable facilities to meet the needs of patients' families. The service had a family room which was available for staff to use when breaking bad news. The room was clean and clutter free in line with trust IPC guidelines.

At the time of inspection, the trust was not routinely allowing visitors into the department.

Staff carried out daily safety checks of specialist equipment. Records showed staff completed daily checks of emergency airway trolleys and resuscitation equipment in line with trust guidelines.

The service did not always have enough suitable equipment to help them to safely care for patients. Staff in the adult minors unit reported that they did not have enough beds available to them. This meant they could not move patients, who were waiting in the department for a long time, from a trolley to a bed. This put frail patients at increased risk of harm from pressure ulcers.

Staff described an incident where an elderly patient had come to harm falling from a chair in the waiting area because there were no trolley spaces available.

Staff in the minors unit did not have access to enough pressure relieving equipment for patients who had long waits on hospital trolleys. We saw staff used pillows to relieve risks of pressure ulcers for patients.

After our inspection we spoke with the service leads who had taken action to introduce additional equipment in the form of pressure relieving mattresses for trolleys and pressure relieving seat cushions for chairs.

Staff disposed of clinical waste safely. Staff carried out waste segregation in line with trust policy. Staff labelled sharps bins and had not overfilled them.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

Patients who self-presented at the ED were greeted by a navigator. The navigator was an experienced senior RN who took down a brief description of the presenting complaint and then directed the patient to the most appropriate service. They could refer to the onsite services such as the GP, ambulatory care, ear nose and throat, the dental service or direct the patient to book in at reception to be seen in ED if required.

The navigator continually monitored patients waiting in the GP waiting area or the main ED waiting area for any signs of deterioration and could alert patients to the medical teams.

Initial assessment

Staff completed risk assessments for each patient on arrival using a recognised tool, and reviewed this regularly, including after any incident. Staff assessed patients who self-presented and those who were brought to the department by ambulance.

Nursing staff used a nationally recognised triage tool to triage patients within 15 minutes of arrival in the ED. During triage, staff completed initial observations using the national early warning scores (NEWS2), symptoms and professional judgement for all patients who were considered to need admission to ED.

Nursing staff prioritised patients to be seen in order of clinical need and established if they were fit to sit in a chair to wait for treatment or if they required a trolley.

Staff knew about and dealt with any specific risk issues. Nursing staff completed risk assessments for pressure ulcers and falls. Staff completed care rounding, including positional changes, and the use of pillows regularly for those patients identified as being at increased risk of pressure ulcers and gave patients at increased risk of falls a blue wrist band so they were easily identified.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During our inspection we reviewed the nursing care records for three patients who had presented with mental ill health. Staff had completed mental health risk assessments in line with trust guidelines and taken action to mitigate the risks.

The service had 24-hour access to mental health liaison and specialist mental health support. The trust wide mental health team was led by a mental health matron and was available 24 hours a day, seven days a week. The trust had a mental health psychiatrist who was available during normal working hours Monday to Friday. Staff told us the service was very helpful.

Critically ill patients in ED

Ambulance staff pre alerted the ED staff to seriously ill patients who were on their way to the department and who were potentially in need of resuscitation. ED staff used a loud-speaker system to alert the relevant medical staff of the impending arrival and made arrangements to receive them which could include donning the appropriate PPE.

The trust had a hospital ambulance liaison officer (HALO) who was employed by the local ambulance trust daily from 11am for 10 hours. The HALO liaised with ambulance crews and the nurse in charge (NIC) to ensure ambulance patients were prioritised appropriately and help to provide efficient ambulance offload and turnaround.

Patients in ED with confirmed acute stroke could be admitted directly to the Hyper Acute Stroke Unit (HASU).

Urgent and emergency services

Deteriorating patients in ED

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. In the adult ED staff monitored patients using the national early warning scores (NEWS2). Paediatric staff used the paediatric early warning scores (PEWS).

NEWS2 audit data supplied by the trust after the inspection showed at the last audit (September 2021) staff in ED were 100% compliant with the completion of NEWS2. The next planned audit was scheduled for April 2022.

Staff had a good understanding of sepsis. Audit data supplied by the trust showed at the last audit (September 2021) staff in ED were 100% compliant with the theory and completion of sepsis six care bundle.

Patient medical records we reviewed evidenced the use of a sepsis care bundle for the management of patients with presumed and confirmed sepsis. The records confirmed staff undertook appropriate escalation to medical review.

Shift changes and handovers included all necessary key information to keep patients safe. The nurse handover took place at the time of each shift change led by the incoming nurse in charge (NIC). We attended the night shift nurse hand over. The NIC described ongoing concerns from the day shift.

Staff shared key information to keep patients safe when handing over their care to others. Incoming staff received handovers for the patients they would be caring for in their allocated areas from the outgoing staff.

Nurse staffing

The service mostly had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.

The service leads had completed a nurse staffing review using a recognised staffing tool in September 2020. As a result, the trust had undergone an establishment uplift for ED and currently had a vacancy rate of nine whole time equivalent (WTE) band 5 registered nurses (RN).

Managers limited their use of bank and agency staff and requested staff familiar with the service. The trust told us whilst current recruitment progressed for the uplift to the ED new establishment, a cohort of agency staff who worked regularly within the department ensured continuity of staff who were familiar with local systems and processes, supporting care delivery and reducing the requirement for repeated local induction of staff.

Data provided by the trust after the inspection showed in the six months to January 2022, agency RN covered 11% of shifts.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Service leaders reviewed and flexed staffing levels at morning divisional matron huddles and throughout the day to ensure staffing met the needs of the service and the patients and was aligned to Royal College of Emergency Medicine (RCEM) recommendations.

Urgent and emergency services

The service mostly had enough nursing and support staff to keep patients safe. On the day of our inspection, the actual nurse staffing did not meet planned nurse staffing level. Planned staffing was 15 RN, three clinical support assistants (CSA) and four (health care assistants) HCA but the actual number was nine RN one CSA and three HCA.

On the day of inspection, staff escalated shortfalls in the shift nursing template to the Matron for ED, senior staff had brought nurse educators to the department to help mitigate the staff shortages as well as paramedic staff who had been working in the vaccination hub.

The service had introduced extended roles in the service to support the RN. This included practice development nurses, trainee associate care practitioners (ACP) and upskilling HCA to become CSA.

All the nursing staff working in the paediatric emergency department were registered children's nurses.

Data shared by the trust after the inspection showed 73% of ED registered nurses (RN) were compliant with immediate life support (ILS) and advanced life support (ALS).

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 staffing levels and skill mix.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The clinical lead had carried out a medical staffing review in August 2021 using a recognised staffing tool. The review identified areas of staff shortage at certain times of the day. The service had introduced an additional shift of junior staff to ensure appropriate staff skills and numbers were available at times of peak attendance.

Data supplied by the trust after the inspection showed that in January 2022, 11% of medical shifts were covered by locum doctors. The trust explained this was due to sickness. Middle grade and specialty doctor recruitment is ongoing to reduce locum requirements. The majority of locum shifts are at weekends and filled by doctors that have previously worked in the department.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. A mix of 16 middle grade and junior Drs worked overlapping shifts from 8am until midnight with five middle grade Drs working overnight from 10pm. Data shared by the trust after the inspection showed 45% of relevant ED medical staff held a current advanced paediatric life support (APLS) or European advances paediatric life support (EPALS) qualification.

The service always had a consultant on call during evenings and weekends. Consultant cover was not in line with RCEM which recommend consultants provide 16 hours of cover per day as opposed to the 14 hours provided in the department. The service mitigated this by having two consultants working overlapping shifts from 8am until 10pm on weekdays and 8am until 4pm at weekends then providing an on-call service from home outside of these hours.

The service was continually looking to recruit additional consultants to address the RCEM recommendations.

Records

Urgent and emergency services

Staff kept records of patients' care and treatment. Records were clear and stored securely. However, records were not always contemporaneous or complete and not always easily available to all staff providing care.

Staff in ED kept a combination of paper records, stored in closed filing cabinets, and electronic care records. We reviewed five paper nursing care records and four electronic medical records.

Patient notes were not always completed, and all staff could not always access all the relevant information easily. Numerous log ins and systems which did not interface created risks of lost information, and delays in staff accessing the appropriate information. Service leads described difficulties with the computer system throughout the department.

We had identified concerns with the patient records system during our last inspection (December 2019). We observed nursing staff completing care rounding and observations on patients in minors, but these were not always documented in the paper care records we reviewed. Two staff told us they did not always have time to document the care interactions they had carried out.

The trust was looking to pilot a booklet for staff to complete for patients in the department to go some way to mitigate risks of combination paper and electronic records.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The service had a dedicated pharmacy team of two pharmacists, five pharmacy technicians which was based in ED and operated out of a 'satellite pharmacy' there seven days a week.

Staff reviewed each patient's medicines regularly. Staff in ED input patient details into an electronic prescribing and administration (EPMA) system for patients who had the decision to admit made. These details could be viewed by the pharmacy team which allowed them to start working on patients' medicines reconciliations while patients were in ED. Therefore, this was all in place and ready for when patients were transferred to a ward.

Staff told us there had been medicine errors in ED which had been identified when patients went onto wards. Errors had been attributed to both electronic and paper prescribing records that were in use in the emergency department. We escalated this at the time of inspection.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service worked with others in the wider system and local organisations to plan care to meet the needs of local people and the communities served.

Urgent and emergency services

The trust had agreed and signed a joint policy with the ambulance service, other acute trusts and the local Clinical Commissioning Group (CCG), that supported ambulance handovers and was aimed to reduce offload delays in response to the addressing ambulance handover delays.

The trust ensured patients were seen by the most appropriate professional. The service provided a navigator at the front door to the ED. This was a role carried out by a senior nurse and involved obtaining a brief history from the patient and then navigating them to the most appropriate service in the hospital. This could be the GP service, ambulatory care, ophthalmology, ear, nose and throat or the ED.

The service ensured professionals had a clear understanding of alternatives to the ED to have their care needs addressed. The service clinical lead had set up engagement meetings with the local GP. The outcome of the first meeting was that GPs had become aware of changes to service provision for urology and ear, nose and throat services out of hours.

The service ensured patients had a clear understanding of alternatives to the ED to have their care needs addressed. The trust used social media to provide information to patients about the alternatives to attending ED and to encourage self help such as attending their local pharmacy or using the NHS 111 service.

The service tailored information to reach the local population. Service leaders had a good understanding that the area they served was a tourist area. During peak holiday season the service provided additional GP services in the town centre. The service used social media and distributed cards to direct patients to this service in the first instance.

Primary care services had direct access to speciality teams. GP services can refer patients directly to a speciality, or to ambulatory care, surgical assessment unit and emergency admissions discharge unit (EADU). This means patients do not have to attend the ED.

The trust had initiatives in place for admission avoidance such as the virtual ward and the use of the ambulatory care model. Data provided by the trust showed that an average of 14 potential admissions were avoided per day in January and 16 in February 2022.

The service worked with other providers to meet the needs of people. The service had an onsite GP service provided by an external provider between 10 am and 10pm. This service enabled up to 50 patients per day to be seen by a GP, who were treated and discharged or referred to a speciality without being seen in the ED.

The service had adapted and evolved to meet demand and new or emerging needs. Service leads monitored attendance figures every two weeks and had made changes to paediatric staffing and the GP service to fit times of peak demand.

Access and flow

People had longer waiting times for treatment and admissions compared to the England average and the national standards.

Data from NHS England A&E Attendances and Emergency Admissions showed there was a considerable reduction in the trust's type 1 emergency department (ED) attendances, from 7,792 (July 2021), to 5,656 (January 2022). However, there was a considerable increase in the trust's type 3 attendances, from 64 (August 2021) to 790 (January 2022). A type one attendance is 'major' and the patient may require full resuscitation facilities. A type three attendance is for more minor injuries or illness.

Urgent and emergency services

The trust had introduced an ambulance cohort trolley bay. This three cubicle bay was at the ambulance entrance and, although the patients here were still the responsibility of the ambulance service and were cared for by a paramedic who was based at the hospital, they were in the line of site of the nurse in charge (NIC) and medical staff if they were to deteriorate. The three ambulance cohort spaces were available for use seven days a week to provide full clinical facilities, piped oxygen, suction and a medical facility to enable the ambulance service to provide clinical care to patients prior to handover to ED staff. This enabled ambulance crews to unload their patients and return to being ready quickly.

Flow

Managers monitored waiting times and made sure patients could access emergency services when needed, however, patients did not always receive treatment within agreed time frames and national targets. The trust's median time to treatment met the 60 minute standard in 23 out of 24 months from January 2020 to December 2021.

Data from NHS England Urgent and Emergency Care daily sitreps and Association of Ambulance Chief Executives showed from October 2021 to December 2021, 18.5% of ambulance handovers took more than 60 minutes. Between November 2021 and February 2022, the percentage of patients waiting over 60 minutes to handover was mainly higher than the regional and England averages.

The service had introduced a decision to admit (DTA) area. This area was used to cohort five of the most well patients who were waiting for admission to a ward. Because the patients here were of a lower acuity, staffing numbers were also lower and this enabled more staff to be available to care for the more sick patients.

12h waits

Staff told us there were often delays in finding beds once the decision to admit (DTA) had been made.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, the trust's median total time in ED for those patients who had a decision to admit (DTA) was considerably longer than the England average from May 2021 onwards. As of December 2021, the trust's median total time in ED was seven hours 45 minutes. This was the third highest figure in the East of England. The England average was five hours 24 minutes.

Data from NHS England Urgent and Emergency Care monthly sitreps showed the trust reported the highest number of patients waiting over 12 hours from the decision to admit to admission in the East of England region in June, August, October and December 2021. In January 2022 the trust reported 320 such waits, the second largest number in the region. This was because of the delays in transfer of care when discharging patients from wards back into the community.

One patient who required a side room for isolation had been waiting in the ED for 47 hours since the DTA to be moved to a ward.

At 1pm during the inspection there were 50 patients in the ED, of these, 28 patients had already had decisions to admit (DTA) and were waiting for beds on wards. This meant staff were not able to accommodate new patients arriving in the department.

Urgent and emergency services

At the time of our inspection one patient who was waiting to be admitted to mental health services had been in the department more than 46 hours. The mental health liaison team were involved with patients care and staff completed risk assessments until the patient was transferred to a mental health bed.

The trust's median total time in ED for non-admitted patients increased considerably from March to August 2021. There was then a smaller reduction. In December 2021 the trust's median time was three hours four minutes, this was worse than the England average of two hours 41 minutes. Data from NHS Digital A&E quality indicators.

Bed and flow meetings

Routine attendance at site operational meetings included silver (Tactical) on call manager, duty matron, site team, ED nurse in charge and hospital ambulance liaison office (HALO).

Staff discussed ED safety and quality issues, staffing, patients with decisions to admit (DTA) capacity, ambulance offload delays and mental health assessment delays as part of their regular patient placement meetings held throughout the day.

We attended the 4.00pm patient placement meeting. The meeting was multidisciplinary. Staff from each service including shared a report of their current situation. This included bed occupancy numbers, number of patients who could potentially be discharged and number of patients waiting to go to a ward.

The provider had a strategy for maintaining patient flow within the department. The ED service leads escalated concerns around flow to the site team at bed meetings. Bed meetings were held throughout the day and had executive lead oversight. The site team held three system wide calls every day, including weekends, with the local ambulance provider and neighbouring NHS trusts as well as the local clinical commissioning group (CCG) and other relevant care providers.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department (ED) was led by a team of managers including the clinical lead for ED, matron for ED, senior nurse for ED and the operations manager for ED. While the team had only been established for approximately seven months, each member was experienced in their role and the team appeared dynamic, patient focussed and progressive.

All the leaders identified that they could not fix all the problems facing the urgent and emergency care service but were very focussed on what they could do for their own department.

The service was working to address sustainability amongst the medical workforce by succession planning; creating opportunities for new consultants to take on more responsibility and develop their leadership skills. Staff could discuss any learning and development they would like at their annual appraisal.

The service leads we spoke with said that executives were visible and approachable in the department and that they could raise concerns without fear. Most other staff we spoke with said they would be happy to raise concerns with their local managers.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All the staff we spoke with told us how proud they were of each other and of the service they provided.

Throughout the inspection we observed staff interacted with each other respectfully and professionally.

The service had taken steps to improve staff wellbeing. These included providing a new fully equipped staff rest area, implementing feedback boxes where staff could leave comments or ideas, and employing a wellbeing nurse who was providing mindfulness sessions for those staff who wished to attend.

The service had recently carried out its own ED specific awards ceremony where staff were nominated for awards by their peers and colleagues and received a prize if they were chosen. Staff spoke enthusiastically about this event.

The service had access to a trust wide clinical wellbeing lead and staff knew who the freedom to speak up guardians were within the ED.

The service collected patient feedback via a QR code on a mobile phone or by a paper based system. The service leads had acted on patient and staff feedback and introduced a security guard in the ED waiting room overnight and had put up electronic screens providing communication to patients about wait times and any delays.

Service leads ensured duty of candour (DoC) was completed at the earliest opportunity where any moderate harm incidents had occurred. Staff followed up DoC at incident panel meetings which were held three times per week and ensured patient records were kept up to date.

Minutes of the emergency department clinical governance meeting held 14 May 2021, 14 July 2021 and 22 September 2021 evidenced service leads had oversight of DoC.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

All the staff we spoke with could describe the process for escalating concerns around capacity. Service leads described how they had implemented changes to the service as a result of learning from the investigation into the activation of the full capacity protocol. For example, speciality doctors attended the ED to review patients rather than waiting for them to be admitted to the ward. This meant patients could be seen and discharged quicker.

Urgent and emergency services

Service managers monitored times to speciality review. This enabled them to feed back any areas of concerns directly to the relevant speciality so that they could take appropriate steps to improve the patient wait time in the ED.

Service leads monitored performance of the service via a programme of internal and external audit. Audit performance was a standard agenda item at clinical governance meetings.

Service leads described in detail the top four risks faced by the service. The risks they described were recorded on the service risk register. All risks had risk owners assigned, detailed the mitigating actions in place and had been reviewed regularly.

The service had robust arrangements for identifying, recording and managing risks and mitigating actions. Minutes of the emergency department clinical governance meeting held 14 May 2021, 14 July 2021 and 22 September 2021 evidenced service leaders discussed risks.

The trust held clinical governance meetings on alternate months, but some recent meetings had been cancelled due to operational pressures around staffing and workload, so there was a pause in meetings from May 2021 to October 2021.The next ED clinical governance meeting was scheduled for 25 February 2022.

Minutes of the emergency department clinical governance meeting held 14 May 2021, 14 July 2021 and 22 September 2021 evidenced service leads had oversight of complaints, service risks, incidents and staffing.

The service took into account potential risks when planning services and was looking at ways to address seasonal fluctuations in demand, for example increase in attendance to the minors area due to holiday makers in summer.

The trust was about to start building work which would increase the size and capacity of the minors area.

Outstanding practice

We found the following outstanding practice:

Urgent and emergency care

The navigator role ensured self-presenting patients were greeted immediately on arrival at the department and streamed to the most appropriate service quickly.

The ambulance cohort area ensured patients could be unloaded from ambulances and into the line of sight of nursing and medical staff even when the department was full.

Areas for improvement

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

Action the trust SHOULD take to improve:

Urgent and emergency services

Urgent and emergency care

The trust should ensure that staff in the minor area have access to enough pressure relieving equipment for patients who have long waits on hospital trolleys. (Reg12. Safe care and treatment).

The trust should ensure prescription records in ED are streamlined. (Reg12. Safe care and treatment).

The trust should consider streamlining patient care records in the department. (Reg12. Safe care and treatment).