Care Quality Commission

Croydon Health Services NHS Trust

Croydon University Hospital

Inspection report

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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?	**Requires Improvement**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Croydon University Hospital

Requires Improvement 

We carried out an unannounced focused inspection of the emergency department (ED) at Croydon University Hospital on 21 and 22 September 2021.

We carried out this inspection as a follow up to concerns about the quality and safety of the service raised in previous inspections, including the care of patients with mental health problems. The emergency department (ED) had been issued with requirement notices in February 2020 and imposed conditions following a focused inspection to the care of mental health patients in December 2020. At our last comprehensive inspection (February 2020) we rated the trust as requires improvement overall and the urgent and emergency service as requires improvement.).

As this was a focused inspection, we did not inspect all key questions. Our priority was to identify if the service was safe, responsive and well led and monitor progress since the previous inspection.

We found improvements had been made in the care of patients with mental health problems. However, during our inspection we identified breaches of regulation 12; safe care, and of regulation 17; governance. After the inspection we told the trust it must make improvements issuing the provider with a requirement notice.

Our rating of services stayed the same. We rated them as requires improvement because:

- Infection and prevention control was not assured all the time within the ED. Overcrowding in the paediatric waiting area and the waiting area reserved for possible adult COVID positive patients represented risks of infection prevention control to patients.
- There was overcrowding in the paediatric ED and we were not assured escalation and social distancing policies were being enforced.
- Resuscitation equipment was not checked daily.
- The ED had nursing staffing shortages which were significant in the paediatric ED.
- Triaging in the paediatric ED did not meet the recommended 15 minute clinical standard.
- The service had a significant backlog of reported incidents to review and close.
- People could not always access the service when they needed it. Waiting times for patients to be admitted, transferred or discharged were not in line with good practice.
- Staff voiced concerns about the workload becoming unmanageable with the continuing increase of attendances and staff shortages in their establishment.
- We were not assured the risk register represented all risks to the department.

However:

- The service had updated their physiological scoring measurement tool in line with clinical guidance.

Our findings

- Patients had access to a psychiatric liaison nurses 24 hours a day. Staff told us although the team were increasingly busy, they were responsive and would see patients within one hour of initial referral.
- The service had improved their risk assessment of patients with mental health concerns. Notes from care plans by psychiatric liaison nurses were readily available and environment risk assessments and actions completed.
- There was a stable leadership team in place
- Staff in the adult ED told us they felt respected, supported and valued by service leaders. They were focused on the needs of patients receiving care.
- The service had an auditing programme in place to support performance improvement, identifying good practice and supporting service development.
- Governance processes had improved since our last inspection.
- The trust addressed the concerns raised in our focused inspection in December 2020 by conducting and external review of care of patients with mental health problems and were taking steps to implement the recommended actions.

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.

During our inspection we spoke with 12 registered nurses, seven medical staff, one health care assistants (HCA) and three other staff including a receptionist. During the inspection we also spoke with the urgent and emergency service head of nursing and paediatric head of nursing and the clinical lead for the department.

We reviewed 17 adult patient records and four paediatric patient records. Of the 17 adult patient records, seven were for patients who attended the ED with mental health concerns.

Urgent and emergency services

Requires Improvement 

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- Infection and prevention control was not assured all the time within the ED. Overcrowding in the paediatric waiting area and the waiting area reserved for possible adult COVID positive patients represented risks of infection prevention control to patients.
- There was overcrowding in the paediatric ED and we were not assured escalation and social distancing policies were being enforced.
- Resuscitation equipment was not checked daily.
- The ED had nursing staffing shortages which were significant in the paediatric ED.
- Triaging in the paediatric ED did not meet the recommended 15 minute clinical standard.
- The service had a significant backlog of reported incidents to review and close.
- People could not always access the service when they needed it. Waiting times for patients to be admitted, transferred or discharged were not in line with good practice.
- Staff voiced concerns about the workload becoming unmanageable with the continuing increase of attendances and staff shortages in their establishment.
- We were not assured the risk register represented all risks to the department.

However:

- The service had updated their physiological scoring measurement tool in line with clinical guidance.
- Patients had access to a psychiatric liaison nurses 24 hours a day. Staff told us although the team were increasingly busy, they were responsive and would see patients within one hour of initial referral.
- The service had improved their risk assessment of patients with mental health concerns. Notes from care plans by psychiatric liaison nurses were readily available and environment risk assessments and actions completed.
- There was a stable leadership team in place.
- Staff in the adult ED told us they felt respected, supported and valued by service leaders. They were focused on the needs of patients receiving care.
- The service had an auditing programme in place to support performance improvement, identifying good practice and supporting service development.
- Governance processes had improved since our last inspection.

Urgent and emergency services

- The trust addressed the concerns raised in our focused inspection in December 2020 by conducting and external review of care of patients with mental health problems and were taking steps to implement the recommended actions.

Is the service safe?

Requires Improvement 

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

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse.

Staff received training specific for their role on how to recognise and report abuse for all patients attending the emergency department (ED).

Staff assessed, monitored and managed risks to safeguard patients presenting with mental health concerns.

Paediatric ED staff completed safeguarding checks on children attending the paediatric emergency department (PED) in line with the trust safeguarding policy. Reception staff described how they used electronic patient records flags to alert staff to any safeguarding concerns they had observed in the patient history or waiting area.

The trust had an up to date safeguarding adults and children policy which staff accessed via the trust intranet. Staff could also contact the trust safeguard lead should any concerns arise.

Cleanliness, Infection prevention and control

We were not assured that the service-controlled infection risk well all the time. The paediatric ED waiting area was overcrowded and control measures to protect patients, staff and others from infection were not in line with trust infection prevention and control policy and social distancing policy. However, staff consistently used personal protective equipment (PPE) and cleaning was carried out routinely.

All areas of the ED were visibly clean.

We checked various pieces of equipment and furniture including chairs and ECG machines. These all appeared clean and dust free.

In response to the pandemic, the trust had implemented designated COVID areas within the ED to maintain patients and staff safety. There were clearly marked areas in the reception area and throughout the department to remind staff and patients of social distancing regulations. However, these were not always adhered to due to the number of people attending. As an example, the paediatric ED was visibly overcrowded with limited compliance to social distancing and enforcing trust measures such as adults using face masks. We also identified that the reception waiting area designated for adults with potential COVID infections was in the corridor with access to the toilets. Although separated, we were not assured that the designated area for potential COVID patients in the ED waiting area allowed enough distancing from other members of the public posing a risk of cross infection.

Urgent and emergency services

The trust had implemented a social distancing within the emergency department protocol to address the increased number of attendances in the department and the risk of overcrowding in the waiting area. However, this policy did not address the waiting area in the paediatric department which was overcrowded. We requested the escalation and social distancing policies for the paediatric ED and were not assured the actions identified in the policy were being followed.

Staff followed specific guidance designed to control the spread of infection. Staff displayed respiratory isolation area posters on the doors entering COVID resuscitation or treatment bays in the majors area. These clearly stated that staff attending these areas should be wearing specific personal protective equipment (PPE). We saw staff following the identified procedures when entering these areas.

Hand washing stations and sanitisers were available throughout the ED. All staff wore scrubs and with arms bare below the elbow in line with trust policy. We observed that staff regularly washed and sanitised their hands.

Managers were actively supporting staff to improve their hand hygiene. Figures for the adult ED for August 2021 identified that the compliance with hand hygiene audit was 94% and 100% compliance with bare below the elbow. This was an improvement on the 53% and 66% compliance recorded in April and March 2021 respectively. For the paediatric ED figures for August 2021 identified that compliance with hand hygiene was 60% and 100% for bare below the elbow. The hand hygiene record had kept low in line with the previous months of March and April which recorded a compliance of 70% and 50% respectively. Bare below the elbow compliance was 100% in these months.

PPE stations were available throughout the department and well stocked with gloves, aprons and masks. Signage on noticeboards and at the entrance to specific areas clearly described what PPE needed to be worn. We observed all staff to be complaint with PPE requirements. However, the most recent auditing of PPE compliance scored 76.6% in the adult ED. The paediatric ED demonstrated a compliance rate of 92% for August 2021 and 85% for September 2021

Staff cleaned equipment and trolley spaces between patients.

Environment and equipment

We were not assured that the design and use of premises always kept people safe.

The adult ED comprised of several areas: reception, waiting areas, resuscitation, triage and majors. The paediatric ED was located within the department in a self-contained unit.

The adult resuscitation area was identified as an area where staff could treat patients who were most critically ill without waiting for them to be confirmed as COVID-19 negative or COVID-19 positive. There was a designated isolation resuscitation bay for COVID positive patients which was clearly identified as such. This area was used for patients who were required resuscitation or aerosol generating procedures (AGPs).

We reviewed seven pieces of electronic equipment and found equipment had been safety checked in line with trust policy.

Staff had easy access to resuscitation equipment.

We reviewed three resuscitation trolleys and found staff had not completed equipment safety checks in line with trust guidance. Whilst two trolleys in the adults ED had gaps of one and three days in a three month period, there were

significant gaps in the trolley checks located in the paediatric ED. We reviewed the latest three months of checks and found that within the last 84 days, 30 days did not have checks completed. This meant that staff could not be assured that the equipment would be ready to use in an emergency. We highlighted this to the trust's senior leadership team and received assurances that checks would be monitored and audited to assure compliance.

The trust had two designated cubicles in the sub wait area which were safe for patients attending the department with mental health crisis. We were also informed that should these cubicles be in use and capacity demand the use of the majors area, risk assessments to the environment and pre-assessed cubicles would be used. The service had put in place assurances that these areas were recorded as being in use by mental health patients as well as ensuring compliance with the relevant risk assessment and observation policy. This was an improvement in relation to the inspection carried out in October 2020 where the trust did not have these procedures.

The footprint and number of attendances in the paediatric ED did not provide for a safe environment in the paediatric waiting area. We observed that the waiting area was overcrowded and did not allow for safe social distancing. Additionally, the waiting area was noisy and did not provide a comfortable place for patients waiting as some patients, their parents or carers had to wait standing. We did not see escalation plans for this being fully followed and highlighted our concerns to the trust. On response the trust replied that the paediatric ED waiting areas were omitted form the trust situation reports (SitRep), and as such were not routinely discussed at the safety/bed meetings held regularly throughout the day and at 10pm. The trust committed to taking immediate action to amend the SitRep template to ensure that this was considered at these meetings going forward.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They acted to remove or minimise risks. Staff identified and acted upon patients at risk of deterioration. However, during inspection the paediatric ED did not meet the clinical standard for triage waiting time.

The ED had an effective streaming and triage process for patients who attended the adult ED. Patients who were admitted via ambulance where also streamed and pre alerted before arrival and allocated to the right areas of the ED.

Staff used patient symptoms and clinical observations to stream patients immediately when they self-presented at ED. Staff could then refer patients to the GP services, urgent care centre or admit to the main ED. Patients identified as requiring further treatment in the department were then directed to the triage team for further investigations.

We observed six adult patients who went through streaming and triage. Streaming for all patients was completed within the 15 minutes to assess clinical standard. Triage also worked effectively with skilled staff undertaking the triage process supported by a recognised triage tool. Triage nurses were skilled and completed initial observations using the national early warning scores (NEWS2), symptoms and professional judgement for all patients.

Staff identified patients at increased risk of harm. In 10 adult records reviewed, nursing staff had completed risk assessments for pressure ulcers and falls.

Staff we spoke with were aware of clinical pathways. Pathways were easily accessible throughout the ED and on the trust intranet.

Urgent and emergency services

Reception staff in the paediatric ED took notes and recorded a brief patient history and description of symptoms which was then reviewed by staff in case a quicker response was needed. As patients were waiting for triage the team of nurses did a check of the patients which was described as “eyeballing” to assess if any children needed to be escalated. We were told that for those under five ’s this was monitored more closely and that for under one’s eyeballing was done as a catch up and meet.

Triage in the paediatric ED was done by done by an appropriately trained senior band 5 nurse or above. In periods of high attendance this was escalated to two nurses. Nurses used a recognised triage tool to support their decision making. During inspection we reviewed the triage waiting times during the afternoon and evening and found that patients were waiting more than one hour for triage. This was over the 15 minute clinical standard and there was an increase risk to patients as sepsis screens, PEWS, and pain relief could be delayed. However, the two triage nurses were risk managing the queue picking up high risk conditions first. We observed that patients waiting for triage were minor injuries and illnesses.

We reviewed seven adult risk assessments for patients who had presented with a mental health crisis. Staff had completed these appropriately using the trust’s risk assessment matrix. Where required psychiatric liaison plans were in place and assessed the needs of the patient or took steps to mitigate risks of harm to them. This was an improvement in relation to our focused inspection in November 2020.

Staff in the emergency department (ED) had 24-hour access to adult psychiatric liaison nurses (PLN) and specialist mental health support from a mental health trust if they were concerned about a patient's mental health condition. PLN’s had a target time of one hour to assess patients after referral. All PLN assessment we reviewed were completed within this timeframe. This was an improvement in relation to the last inspection as notes and assessments by the PLN were clearly available to ED staff for review and establishing an initial treatment plan.

Children attending the paediatric ED with mental health concerns were first assured they were medically well and then referred for further assessment and treatment to a mental health service. This service was available during the daytime. At night, the paediatric ED was reliant on the local mental health trust’s on call team services. We were told this night time arrangement often resulted in delays until children were assessed

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 made arrangements to receive them which included donning the appropriate PPE and identifying the right clinical professionals to be available to treat them

The trust had a hospital streamer who liaised with ambulance crews and the nurse in charge to ensure patients were prioritised appropriately and helped provide efficient ambulance offload and turnaround.

In the adult ED staff monitored patients using a nationally recognised physiological scoring measurement tool. The trust had updated this tool to the recommended clinical version identified in care guidance. This was an improvement in relation to our inspection in February 2020. Paediatric staff used a paediatric nationally recognised physiological scoring measurement tool. Staff recorded observations in line with guidance on the completion of the observation tool.

The nurse handover took place at the time of each shift change led by the nurse in charge. We attended the night shift nurse hand over. The nurse in charge described any patients of concern in the department and any ongoing concerns from the day shift.

Records

Urgent and emergency services

Staff had all the information they needed to deliver safe care and treatment to people

People's individual care records, test results and observations were written and managed in a way that kept people safe.

All the information needed to deliver safe care and treatment were available to relevant staff in a timely and accessible way. This was an improvement in relation to the inspections in 2020 All 17 records we reviewed having had complete risk assessments (including the risk matrix for mental health patients), updated care records monitoring the progression of patients and their physiological and mental health needs and also including recorded reviews and referrals.

Nurse staffing

The adult ED service 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. Nursing staffing was reliant on bank and agency workers to complete established rotas. However, although they had the appropriate skills and qualifications, the paediatric department presented significant staff shortages in their establishment and we saw that not all shifts had been fully staffed.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

On the day of our inspection we saw that the actual count of nursing staff in the ED matched the planned staffing count. The department was supported by emergency nurse practitioners whose shifts were staggered throughout the day.

The adult ED service had vacancies for band 6 and band 5 nurses. The service had rolling adverts in place to attract staff. Additionally, managers were aware of the staff shortages and a winter pressure plan was in place to increase nursing staffing.

The service did not meet the royal college of nursing baseline emergency staffing tool guidance (BEST). We observed that there was one nurse for four patients in the majors area and one nurse to two patients in the resuscitation area. BEST guidance suggests staffing of one nurse to two patients in majors and one to one care in resuscitation.

The ED also had two practice development nurses who supported staff development in key areas such as patient group directives to give medication at triage and major incident training.

The ED had nine vacancies in 11 existing registered mental health nurse (RMN) roles. We saw evidence that the service was continuously trying to recruit to these roles and increasing the support offered to RMN's.

Where the service had vacancies, this was mitigated by giving regular lines of work to bank and agency staff with specific ED training. This included the use of agency RMN's to support the delivery of mental health care.

All senior nursing staff in the children's emergency department were registered children's nurses. This was in line with guidance set out in the Royal College of Paediatrics and Child Care: Facing the Future: Standards for Children in Emergency Care Settings.

In the paediatric emergency department nursing staffing presented a large number of vacancies. Of a planned establishment of 40 whole time equivalents (WTE) the service had 8 vacancies for band 6 nurses, two band 5 vacancies, and one band 7 vacancy. We were also told there were three staff members on long term sickness.

Minutes from the August 2021 ED management meeting stated that all paediatric advance nurse practitioners had resigned due to a number of reasons, including a lack of career progression. However, we were informed that in the past months four paediatric advance nurse practitioners out of the substantive workforce of 5.11 had resigned. This resulted in four advanced nurse practitioner vacancies in the current established workforce. The service was being supported by an NHS body to receive further support and enhance recruitment strategies.

The service was mitigating nurse staff shortages by rostering adult ED nurses, also trained to care for children and young people, to the paediatric ED.

The paediatric ED were not always able to fill their shifts. We saw that between 13 September to 18 September 2021 only one shift pattern was fully complete. Three days had one shift not filled and two days had two shifts that were not filled. We were told that the paediatric ED had adjusted their shift patterns to ensure that there was always a band 6 paediatric ED nurse or more senior role available to support the delivery of care and support newly trained ED nurses in their roles.

Managers tried to fill shifts using bank staff, offering extra hours and by deploying specialist nurses or those with clinical skills employed in other roles to the frontline.

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. However, we could not be assured the paediatric ED had sufficient consultant cover.

Consultant cover in the adult ED was line with Royal College of Emergency Medicine (RCEM) which recommends consultants provide 16 hours of cover in the department. Consultants were typically present in the adult ED from 7:30am to 12pm, seven days a week. A consultant was on call at all other times. Other medical staff were rostered to provide 24 hours a day cover for, seven days a week. There was always a registrar on duty 24 hours a day, seven days a week.

Consultants were supported by a team of junior doctors. Middle grade doctors worked on overlapping shifts as did the foundation year doctors in the department.

We reviewed four random days from September 2021 in the adult ED medical rota and found very few gaps.

The service ensured that any locum doctors where know to the service.

There were low turnover rates for consultants in the service.

The paediatric ED used a hybrid medical cover model with the adult ED. We heard there was a paediatric ED consultant usually working a 9am to 5pm shift with an additional paediatric ED consultant doing approximately two shifts per week between 2pm and 10pm. To cover the remaining times and nights the service had one general paediatric consultant on site until 10pm, 7 days a week and on call over night. Shift arrangements ensured that the service had access to at least one paediatric registrar and one senior house officer out of hours and during night shifts.

Urgent and emergency services

We were told medical staffing was additionally supported with the use of advanced nurse practitioners, GP's from the urgent care centre and foundation year two doctors. In addition to this, the service used sessional doctors to support the service as well as consulting with paediatric ward consultants and registrars specially when there was insufficient specialist consultant cover.

Incidents

The service did not manage patient safety incidents well. Not all incidents had been investigated and lessons learned shared with the whole team and the wider service. However, staff recognised and reported incidents and near misses.

Staff knew what incidents and near misses to report and how to report them. Staff also reported serious incidents in line with provider policy.

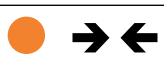
We were told that a total of 1586 incidents relating to the Emergency Department (including Paediatric ED) were still outstanding for closure and review. We were told that leaders within the ED and patient safety team reviewed daily reported incidents to ensure that any incidents of a serious nature were flagged to colleagues for prompt investigation and reported to the correct authorities. We highlighted our concerns to the trust that vital information and patient safety could be compromised by this. We received assurances from the trust that it has set itself a target of having closed all incidents older than two months on a rolling basis by 1 January 2022.

We did not see evidence that staff always received feedback from investigation of incidents.

The service had one never event between September 2020 and August 2021. We asked several members of staff if they were aware of this incident and no one was able to recall it or if changes had occurred as a result of this incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Is the service responsive?

Requires Improvement 

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

Access and flow

People could not always access the service when they needed it and did not received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards.

NHS Digital - A&E quality indicators show during July 2021 the trust received approximately 19,840 attendances at the emergency department (ED). This was slightly higher than the previous month, June 2021, were the ED saw 19,745 attendances. The department saw 161,545 patient attendances between May 2020 to Apr 2021

Urgent and emergency services

NHS Digital - A&E quality indicators shows that during July 2021, the percentage of patients who left the department before being seen was 1%. This was lower than the England average of 1.5%.

Data supplied by the trust showed that from August 2020, there was an increasing trend of patients spending longer than the four-hour target in the ED. Patients spending less than 4 hours in (any type of) ED (%) declined from 93.4% in August 2020 to 82.3% in August 2021. Additionally, patients spending less than 4 hours in ED majors declined from 90.6% in August 2020 to 72.7% in August 2021. However, the service has been performing above the national average which were 74.4% and 66.2% respectively. The operational standard is that at least 95% of patients attending ED should be admitted, transferred or discharged within four hours. During our onsite inspection the night shift handover identified 75 breaches of the four hour standard.

In July 2021 the median total time spent in ED for admitted patients was 456 minutes with the longest time recorded being 1439 minutes.

Ambulance handover data for July 2021 showed that 5.7% patients waited over 60 minutes for handover with the average time of ambulance arrival to initial assessment being 12 minutes. This was meeting the target of 15 minutes from ambulance arrival to initial assessment. During our inspection we reviewed the ambulance handover and offload process. We found assurances that the system was recording, triaging and monitoring patients in line with established policies and procedures between the trust and ambulance provider.

The trust looked at the number of patients re-attending the ED within seven days of their first attendance. In July 2021, 7.2% of patients re-presented. The trust was in the lower second quartile when compared nationally.

Information was available to staff on the status of patients and on the performance of the department through the electronic display screen in the ED. The inspection team requested information relating to patient numbers throughout the day and staff were able to make use of the system to quickly report on the situation at any time.

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

NHS England published A&E Situational Report (SitReps) showed that since August 2020, there had been a notable increase in the number of patients waiting between four and 12 hours from the decision to admit (DTA) to admission. This had increased from 12% in August 2020 to 47% in August 2021. Additionally, the trust was performing worse than the national average which was 24%. During our onsite inspection we reviewed the number of DTA's at one point in the day and found that 15 patients were waiting for admission. The longest wait was 11 hours.

The number of patients waiting more than 12 hours from the decision to admit (DTA) to admission saw an improvement on year on year results. The trust had 22 12 hour breaches in August 2020 and 17 in August 2021

Senior hospital staff discussed bed occupancy, capacity and discharges as well as patients awaiting admission as part of their regular patient placement meetings held throughout the day.

The meeting was multidisciplinary with input from the hospital teams.

Urgent and emergency services

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement because:

Leadership

The service leaders demonstrated the skills and abilities to run a service providing high-quality sustainable care.

The service had a new triumvirate leadership team consisting of a general manager, a head of nursing and an emergency department clinical lead.

Leaders we spoke with understood the challenges the department faced and were developing strategies to address these. They worked coherently as a team.

Staff spoke well of the leadership team and described them as approachable, knowledgeable and supportive.

Vision and strategy

Leaders had a clear vision and a credible strategy to deliver sustainable care to people who used services.

Leaders had a clear vision and strategy to achieve their priorities and deliver good quality sustainable care. This was an improvement in relation to the February 2020 service inspection as we were able to see the plans, governance processes and delivery targets that were established or soon to be delivered by the leadership team.

We heard how leaders wished to create a more open culture with staff and provide staff with better development opportunities. As a new leadership team this was part of their key objectives.

Culture

Staff in the paediatric ED felt staff shortages were impacting on morale and delivery of care. Staff in the adult ED also voiced concerns regarding their workload management. However, staff felt respected, supported and valued by local managers. They were focused on the needs of patients receiving care and incorporating the right processes to deliver care.

Staff described the environment in the ED as busy all the time and focused on delivering good care to everyone. However, several staff told us that the workload was becoming unmanageable due to the volume of attendances arriving, majors being full all day with admission patients blocking spaces for other ED patients and medical teams asking ED to do extended tests. We saw these points were raised in ED management meetings. Leaders acknowledged these points and raised them through the governance processes. Additionally, leaders would work clinically to support their staff.

Staff we spoke with told us how they worked as a team and were supportive of each other and of the service they provided.

Urgent and emergency services

Staff interacted with each other respectfully and professionally. They also described managers as being supportive by listening to their concerns and supporting the delivery of care in the ED.

Staff described that staffing shortages in the paediatric ED where having a negative impact on staff morale and described this as having a negative impact on the delivery of the service. This was further aggravated by the resignation of all paediatric advanced nurse practitioners in the past months. Staff looked overworked and tired.

Governance

Leaders were establishing governance processes to effectively manage the performance, quality and safety of the service. However, we were not assured the current process for managing incidents was sustainable and able to address the needs of the patients and the service. Additionally, some governance processes were still being implemented at the time of inspection.

Leaders and senior staff discussed incidents, complaints, performance and risks during a monthly ED management meeting. This was further enhanced by the monthly clinical governance meeting. Recording and dissemination of these meetings had improved significantly since our last inspection in February 2020 as we were now able to review meeting minutes, actions and identify leads for delivery of these actions.

The new leadership team was looking to further strengthen governance processes and had developed a proposed interim governance structure which was aimed at providing greater oversight of ED quality improvement, ED corporate governance and ED clinical governance. The proposed governance structure also looked to incorporate other parts of the department such as estates, information technology, portering and security into the operational delivery group meeting ensuring a more whole team approach to governance.

We were not assured that current processes and tools for the management of reported incidents was sustainable or reliable. We were told that leaders within the ED and patient safety team reviewed daily reported incidents to ensure that any incidents of a serious nature were flagged to colleagues for prompt investigation and reported to the correct authorities. However, the ED had a total of 1586 incidents (including Paediatric ED) still outstanding for review and closure. This could lead to a culture of underreporting, lack of learning from incidents and that although leaders had oversight of daily reports, significant incidents could be missed due to lack of investigation.

It was felt by the inspection team that as the paediatric ED reported to two different directorates (integrated adult care and integrated women's, children's and sexual health directorate) and their respective governance structures, accountability for this department's governance and risks was at times unclear or could be duplicated. We heard during the inspection period, that a more focused and regular paediatric ED senior staff and management meeting has recently been established to ensure all activity within the paediatric ED is reviewed and appropriately actioned.

Governance processes that assured the development of operating protocols and implementation of policies and terms of reference were strengthened in relation to our February 2020 inspection. We saw through the clinical governance meetings and ED management meeting minutes there were action logs to monitor progression of these activities and that meeting minutes reflected actions and people responsible for carrying them out. Additionally, we were easily able to access policies and procedures during our site visit such as the standard operating procedure for sub wait area in the ED.

Staff at all levels were clear about their roles and understood their accountabilities.

Urgent and emergency services

Managing risks issues and performance

Leaders and teams used systems to manage performance. We saw how the service had addressed most of the concerns raised in previous inspections including concerns related to the care of patients with mental health problems. However, despite identifying relevant risks and issues, recording of these was not held in one place and the risk register did not reflect current risks to the department. Current governance arrangements for the paediatric ED were not supporting a uniformed approach to the management of risks in the department.

Senior staff we spoke with were able to tell us about the risks to the ED and how they were working to reduce them. There was an understanding of what a risk was and how they were identified.

We reviewed the ED risk register. There were improvements to the risk register since our February 2020 inspection. The risk register now clearly identified the risk, a risk description, the risk rating, controls, assurances and action plans. However, we were not assured that risks to the department were regularly reviewed and that new risks identified through the ED management meeting were being reflected on the risk register. As an example, the challenges with staffing and staff resignations described in the ED management meetings in August and September 2021 were not identified as a risk on the risk register. Additionally, the most recent risk opened on the risk register was recorded in November 2020. We highlighted our concerns to the staff member responsible for updating the risk register and were told there was a general awareness of the risks as they were recorded in the management meetings along with the actions associated to them. We were also told that due to time constraints and technical issues it had been challenging to introduce new risks to the ED risk register. We were told that the existing risks had been updated and reviewed. The inspection team identified that this was difficult to assess as none of the actions in the risk register were dated and the only timeline record was when a risk was introduced and next due for review.

We were also concerned that the risks associated to the overcrowding in the paediatric ED waiting area were not identified in any risk record or management meeting despite staff reporting concerns to us that this was a daily risk due to the increased number of attendances. We highlighted our concerns to the trust regarding this matter who recognised that the paediatric ED waiting areas were omitted from the trust situation reports (SitRep), and as such were not routinely discussed at the safety/bed meetings held regularly throughout the day. The trust provided assurance to amend the SitRep template to ensure that this is considered at these meetings going forward.

We heard plans that the trust would introduce a paediatric integrated unit in the near future which would include a seven bed paediatric short stay unit, which will relieve some ED pressure on patients needing observation up to eight hours.

There was a systemic programme of national and local audits to monitor quality and operational performance in the ED including the care of mental health patients. This was an improvement in regard to our 2019 inspection and demonstrated compliance with the conditions we issued the trust in 2020.

The trust had developed policies and standard operating procedure to manage risk and escalation plans. We were told by leaders that policies and operating procedures were now regularly reviewed, and the service was more proactive in delivering these to support the safe management of the ED. This was an improvement regarding our inspection in February 2020.

The service had undergone an external review to address concerns regarding the provision of care to patients with mental health problems. We reviewed this and found that the trust where actively addressing the findings and had a delivery plan, which they had started to act on, to implement the recommended changes.

Urgent and emergency services

Two staff we spoke with could describe the process for escalating concerns around capacity.

Engagement

There was evidence of sharing information with and obtaining the views of staff, external partners and other stakeholders.

Staff were engaged so that their views were reflected in the planning and delivery of services.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. This was evidenced in the trusts collaboration and start of implementation of the recommendations outlined in the external mental health review as a result of legal requirement issues by CQC in the 2020 inspection.

Governance processes assured that engagement with partners and stakeholders was recorded and information could be shared with staff. This was evidenced through the mental health trust and ED interface meeting. This was an improvement in relation to our 2019 and 2020 inspection.

The service was transparent and open with all stakeholders about performance.

Areas for improvement

MUSTS

We took enforcement action against the trust in the form of a requirement notice because there was a breach of the legal requirements. In summary the reasons we issued this notice were:

- The trust must ensure all staff comply with all trust infection prevention and control guidance in order to minimise the risk of the spread of infection. (Regulation 12).
- The trust must ensure all staff comply with all trust escalation policies in order to minimise the risk of overcrowding in waiting areas. (Regulation 12).
- The trust must ensure that all resuscitation equipment in the ED is checked in line with trust guidelines (Regulation 12).
- The trust must ensure they comply with their delivery plan so that all incidents are adequately assessed, reviewed, investigated and lessons learnt shared to maintain good governance and oversight within the department to ensure patients are protected from potential harm. (Regulation 17).
- The trust must ensure that risks to the department are reviewed and recorded regularly and that there are clear timely plans to eliminate or reduce them (Regulation 17).

SHOULDS

Action the trust SHOULD take 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.

Urgent and emergency services

- The trust should ensure nursing staffing levels in the paediatric ED are always safe and meet patient needs (Regulation 12).
- The trust should ensure that 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 continue to engage with staff and find ways to address their concerns

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one CQC mental health inspector and three specialist advisors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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