Royal United Hospitals Bath NHS Foundation Trust

# Royal United Hospital Bath

## Inspection report

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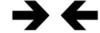
## Ratings

| Overall rating for this service | Good |
| --- | --- |
| Are services safe? | **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 Royal United Hospital Bath

**Good** 

We carried out a focused inspection of The Royal United Hospital Bath urgent and emergency care service on 4 January 2021 as part of our winter pressures programme. As this was a focused inspection, we only inspected parts of our key questions: safe, responsive and well led. We did not inspect effective or caring. Urgent and emergency care was the only service we inspected. We took into account nationally available performance data and concerns we had received about the safety and quality of the service. We also reviewed concerns identified at our last inspection in September 2018 in relation to safe staffing, crowding and paediatric care.

Our inspection had a short announcement (a few hours) to enable us to observe routine activity. Before the inspection we reviewed information we had about the trust based on the intelligence we had received. Due to the narrow focus of this inspection, we did not change the rating of the service at this inspection. Our rating of the service therefore stayed the same as requires improvement.

We found:

- The Royal United Hospital Bath emergency department did not always have enough staff with the right qualifications and updated training to keep patients safe from avoidable harm and to provide the right care and treatment at all times. There were concerns about the level of senior medical staff on duty at night due to the complex layout of the department and lack of visibility for some patients. The design of the environment meant social distancing in some areas was difficult and this could lead to overcrowding in the waiting area at busy times. Triaging and the ongoing care and treatment of children was not always undertaken by nurses with paediatric qualifications. Some patients' medical records did not state the time the patient was reviewed by the doctor.
- Patients could access the service when they needed it but often had to wait longer than the national standard for a decision or treatment and a bed if they needed to be admitted. Demands on services throughout the hospital often resulted in patients in the emergency department or in ambulances waiting for beds. For a number of years, the emergency department's performance against national waiting time standards was worse than the NHS constitutional standards and the national average for England. However, no patient had waited for more than 12 hours during 2020 and fewer patients that the national average waited over four hours. As with most of the rest of the emergency departments in England, this performance was deteriorating in the last six months of 2020 and the winter months particularly. There was a need to resolve a difference in opinion around the responsibility for patients remaining in ambulances and oversight of their care and treatment.
- Service leaders had procedures and escalation plans to follow for managing periods of heavy demand. However, the action plan devised to improve service provision was in its early stages and had not had time to impact on improving performance.

However:

- The service controlled infection risk well and dedicated areas had been established to protect staff and patients from cross infection during the COVID-19 pandemic. Staff knew how to keep patients safe from abuse and how to report this.

# Our findings

- Although the service did not always have enough nursing staff, particularly at night and not enough trained children's nurses to ensure safe care was always provided managers regularly reviewed staffing levels and the skill mix where possible to increase numbers of nursing staff.
- The service liaised with other health care providers to help reduce the demand on the emergency department. This involved signposting patients to other appropriate health care settings which were able to meet their needs.
- A new leadership team had been appointed both at service and executive level. They were working on an action plan to improve the service provision and outcomes for patients. They had the skills, knowledge and abilities to run the service and felt strongly supported by the trust leadership team. The trust and the emergency department leaders understood the priorities and issues the service faced both internally and externally and from the additional pressures of the COVID-19 pandemic. The team were visible and approachable for patients and staff. Staff felt respected, supported and valued.

# Urgent and emergency services

**Requires Improvement**

At the Royal United Hospital Bath, urgent and emergency care and treatment is provided in the emergency department and the urgent treatment centre. The two departments are co-located on the main hospital site and share an entrance and reception/waiting area. The urgent treatment centre is run by a third-party provider with close cooperation with the trust and emergency department. The Royal United Hospital provides the healthcare practitioners to the urgent treatment centre under a service level agreement with the third-party provider. This report is restricted to the service in the emergency department only.

The emergency department accepts patients transported by ambulance or those who arrive independently. It is open 24 hours a day, seven days a week for adults and children who require emergency treatment. The urgent treatment centre operates from 8am to midnight seven days per week. Walk ins outside of these hours are seen by minors.

From September 2019 to August 2020, the emergency department saw 84,415 patients of which 14,270 were children. These were all attendances at the Royal United Hospital and included patients (adults and children) attending the urgent treatment centre. Attendances for emergencies (known as type 1) were 70,731 (adults and children) for the same period. For the year 2020, attendances fell to 67,150 patients (type 1 adults and children) due to the national fall in patient numbers during the first months of the first lockdown.

The emergency department is a designated trauma unit, accepting patients with traumatic injuries including fractures, head injuries and spinal injuries. Major or complex trauma patients arriving at the department are stabilised and transferred to the closest or most appropriate major trauma centre.

During the COVID-19 pandemic, the hospital has created green and red areas for patients to minimise the risk of the infection spreading. Green areas are for patients with no coronavirus symptoms and red areas are for patients with suspected or a confirmed positive test for coronavirus. The waiting area in the emergency department has a reception area and a triage pod (where patients are triaged by a nurse). Some seats in the waiting area had been sealed off to allow for social distancing for patients and any permitted carers supporting them.

The emergency department has 17 major beds (areas where the most serious patients are treated) with one bed space being used as a “doffing” (taking off and discarding of personal protective equipment) area. The green resuscitation area has space for three adult patients and one paediatric bay. There is also a red resuscitation area for three trolleys. There are six adult high dependency care beds also available. The minors area has three trolley spaces and three chaired spaces. The paediatric minors area has four green spaces and two red spaces. The observation unit has two side rooms and four beds. This was a reduction of two beds to allow for social distancing.

At the time of the inspection, the department was undergoing building work to expand their treatment areas.

## Is the service safe?

**Inspected but not rated**

We did not rate safe, the previous rating of requires improvement remains.

**Safeguarding**

# Urgent and emergency services

**Staff understood how to protect patients from abuse. But not all staff had updated their training on how to recognise and report abuse.**

Staff told us they knew how to identify patients they felt were at risk of abuse. The electronic records system enabled staff to report their concerns using a dedicated form which was sent directly to the safeguarding team at the relevant local authority. Staff told us the trust had safeguarding leads for adults and children who could provide them with advice and support. They knew who they were and how to contact them.

Staff had a screening tool on their electronic records system to assess all children on arrival at the department for any safeguarding concerns. There was a child safeguarding review team who reviewed all children who had attended the emergency department within 72 hours.

Safeguarding children training compliance was as follows: 80% of staff had completed level 1, 78% had completed level 2, and 65% had completed level 3. Evidence provided by the trust showed the remainder of staff had not received the required update training and had not met the trust target of 90%. The trust also told us the compliance rate included bank staff and those on long term sick but excluded staff on maternity leave, adoption leave or career breaks. The pandemic had increased the pressure on their service and reduced the amount of time staff had to complete their training. The emergency department was working on plans to address the failure to meet the trust targets.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff wore the right personal protective equipment to keep themselves and others safe from cross infection.**

Staff used equipment and control measures to protect patients, themselves and others from infection. The premises were visibly clean. We saw a strong presence from the cleaning staff in the department throughout our visit.

We observed staff wearing the correct personal protective equipment (PPE) depending on where they were working. In the red area, staff were in full PPE to protect themselves from patients who had or were suspected of being COVID-19 positive. Staff had received training in 'donning' (putting on) and 'doffing' (taking off) PPE safely to prevent the risks of cross infection. There were areas for staff to carry this out safely away from patients and other staff.

We spoke with senior staff about the use of the Royal College of Emergency Medicine infection prevention and control checklist. The senior staff were aware of this tool and had used it to assess and audit the department for compliance with infection prevention and control guidance. We worked through the content of the tool with the senior staff and they were confident about most of the assessments. The main exception, as reported below, was the ability to always ensure complete social distancing.

One aspect of the guidance was for the department to have a member of staff who was always in high-level PPE and available to provide aerosol generating procedures on a seriously ill patient who arrived without advanced warning. The department had a member of staff who was allocated as the 'PPE hero' who always had a full set of high-level PPE immediately to hand to 'don' as required in such an emergency. The senior team had used their experience and knowledge and assessed this protocol as being safe and effective for their patient group.

**Environment**

# Urgent and emergency services

**The design of the premises did not always keep patients safe and comfortable and within social distancing rules. The trust was not able to observe patients at all times due to limited space. However, we recognised it had not been designed to be used in a pandemic and the trust had endeavoured to make the facilities as safe as possible for patients and staff.**

Due to COVID-19, several seats in the patient waiting area had been sealed off to allow for social distancing and the trust planned to fit plastic screens between back-to-back chairs. The trust had plans for how the department would manage overcrowding in the waiting area during busy times. This included patients waiting outside the department (if clinically appropriate) but no plan at the time on using any other internal areas to ease overcrowding.

The layout of the department and narrow dimensions of corridors made social distancing for staff difficult at times and when ambulance staff brought in patients on trolleys. The main staff workstation was compact which meant social distancing was not always possible. However, we observed staff always wearing face masks to minimise any risks to colleagues and patients.

Building work was underway to improve the layout of parts of the department and to provide additional space.

**Assessing and responding to patient risk**

**Patients had an assessment of their infection risk on arrival at the department and staff allocated them to the correct area. However, not all children were assessed at triage by nurses with the recognised paediatric qualification and not all patients were visible to staff in times of overcrowding or difficulties caused by social distancing requirements.**

All patients were assessed for their risk of COVID-19 when they entered the emergency department. For patients transported by the ambulance service, the risk assessment was undertaken when the crew member handed the patient over verbally to the nurse in charge. This helped to determine which area of the emergency department the patient was placed in to prevent the risk of cross infection. To respond to the risks associated with COVID-19, specific flow charts had been developed and were being used to guide emergency department staff for streaming children and young people with suspected COVID-19 symptoms.

Reception staff told us how they directed patients in accordance with possible risk factors. This included patients who had booked appointments at the urgent treatment centre based in the emergency department. Reception staff alerted the staff from triage that a patient had arrived, and staff would collect the patient records before inviting the patient to be assessed. During our inspection we observed patients being triaged within the 15-minute expected standard. Data from the trust showed they achieved between 70% to 80% for triaging patients within the 15-minute expected standard between October 2020 and January 2021. This was below the national standard of 95%. If reception staff were concerned about any patient in the waiting room, they were able to call for medical assistance.

However, at certain times, as reported above, some patients were not able to remain in the waiting area due to pressure on space and were required to wait elsewhere. In these circumstances, the patients would be assessed for the risk of where they were being asked to wait and there was a clinical criteria used to assess this risk. Nonetheless, these patients were then not visible to staff should their condition deteriorate. If patients were deemed to be able to wait outside of the department contact telephone numbers were taken by staff so they could contact them if required. Patients were told to come back to the department if they felt their condition was worsening whilst waiting to be seen.

# Urgent and emergency services

The senior leadership at the trust told us the emergency department staff took clinical responsibility for patients remaining in ambulances once they had been verbally handed over to the nurse in charge. The leadership team told us when the ambulance arrived at department, an initial handover including the infection control screen was undertaken. At this point the patient was booked onto the computer system. This process was irrespective of whether or not the patient was able to be offloaded from the ambulance. The patient was then the responsibility of the trust. However, the ambulance service retained the patient care until a space become available within the footprint of the department. Cohorted patients within the frailty assessment unit were cared for by dedicated ambulance staff but again remained the responsibility of the trust.

Staff did not see the patient until they were brought into the department once a space had become free unless the ambulance staff informed them the patient was deteriorating. There were escalation processes for ambulance staff to use which included using the emergency department escalation card and deteriorating National Early Warning Score (NEWS). NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. However, somewhat in contradiction of the trust's position on this, members of the senior clinical team told us it was the responsibility for the patient remained with the ambulance crew until such time as the patient was physically in the department. There was no formal process in the department to review and maintain oversight of the patients who remained in the ambulance. The leadership team had recognised they needed to implement a formal process, and this was being developed and was currently being reviewed by their governance team.

If ambulance personnel were concerned about a patient, they would liaise through a senior member of their own staff who was on site to monitor the situation. These were hospital ambulance liaison officers or HALOs. If the HALO was not on duty, staff would talk directly with the nurse in charge.

There were systems for streaming children attending the department through the main waiting room once they were booked in by the reception staff. Children were directed to the paediatric waiting room where they were triaged by the main triage nurse between the hours of 8am and midnight. After midnight until 8am they would be triaged by the paediatric qualified nurse if they were on duty. The leadership team told us from middle of January 2021 they were providing a dedicated paediatric nurse to cover the paediatric unit from the hours of 2pm to 10pm weekdays. A junior doctor was also allocated the paediatric unit during this time. The leadership team were working on this to provide the same cover during the weekends.

Triaging of children was not consistently undertaken by qualified paediatric nurses due to shortages of these staff. There is a national shortage of paediatric qualified nurses throughout the region and many NHS trusts have struggled with recruitment. To mitigate the risk the trust told us emergency department nurses were required to complete an in-house paediatric teaching programme provided by advanced paediatric life support instructors and an emergency department consultant. The programme included topics such as paediatric triage, septicaemia, respiratory conditions in children, seizures, injuries, abdominal pain/ rashes and safeguarding. Staff could also complete an additional module called "spotting the sick child". However, although it was requested, the trust has not provided evidence on the number of emergency department nurses who had completed this additional clinical training. They trust told us it was working on a centralised record which would be available at the end of January 2021.

To manage the risks around the shortage of qualified paediatric nurses, there was an appraisal lead, who was a senior sister, and an emergency department paediatric nurse who were designated to sign off emergency department nurse competencies on the above training modules. New starters were allocated time to work alongside one of the paediatric nurses. The trust also told us paediatric nurses supported staff to manage children in majors, resuscitation and high care to provide learning opportunities in a real time environment.

# Urgent and emergency services

Following our inspection, the leadership team told us they had recruited an orthopaedic nurse practitioner to review children in minors and those waiting for an orthopaedic review to minimise delays and waiting times.

To help further with mitigating the risk of lack of paediatric trained nurses a weekly paediatric bulletin was produced for emergency department staff. This included information on a number of topics, for example, paediatric attendance in the emergency department, performance in relation to the four-hour standard and 'hot topics' for learning.

The trust provided training records which showed that as of 31 December 2020, the number of emergency medicine nursing staff who had completed paediatric basic life support was 69%. This was below the trust's target of 90%. The trust told us paediatric life support training was delivered at face-to-face sessions but had been temporarily put on hold due to the pandemic. To meet the trust target, staff had received notification there were 12 places available on an enhanced life support training course which was due to take place in February 2021. Staff had gone on to secure all the places available. This would improve paediatric life support training compliance to 77%. More staff were planned to attend this training when more dates and places became available.

If children met the criteria for direct admission to the paediatric admissions unit, this was arranged by the triage nurse. When assessed, a child might otherwise be moved to resuscitation or the urgent treatment centre, otherwise they remained in the paediatrics emergency department area. Children arriving by ambulance were triaged initially by the nurse in charge and directed to the paediatrics area, resuscitation or paediatric admissions unit.

**Nurse staffing**

**The service did not always have enough nursing staff, particularly at night and not enough trained children's nurses to ensure safe care was always provided. However, managers regularly reviewed staffing levels and the skill mix where possible to increase numbers of nursing staff.**

Nursing staff levels at night did not always meet the planned numbers required. We checked the nursing duty rotas for five nights and found each shift was recorded as being below the planned number of qualified nursing staff. However, on some nursing shifts (three of the five days of rotas we examined) the number of qualified nurses on duty exceeded the planned numbers required during the day. This meant extra nursing staff were on duty to meet the growing demands of the service and the needs of patients. We were aware of staff being drafted into work in the department to support short-term unplanned absence where possible. We also observed senior staff taking frontline clinical roles to support their team in times of need.

The emergency department did not have enough paediatric trained nurses to meet the recommendations set out by the Royal College of Paediatric and Child Health (RCPCH). The recommendation states that every emergency department treating children must be staffed by two registered children's nurses at all times. They were not meeting this recommendation. Staff told us they aim to have one paediatric nurse on each shift but only achieved this only 50% of the time. However, we recognised there was a national shortage of paediatric trained nurses across the region and recruitment had been difficult. Additional training had been provided to some qualified adult nurses as reported above to reduce the risks and improve outcomes for children in providing safe care and treatment. Nursing staff on higher grades (band 6 and 7) were required to complete the additional paediatric training and the department allocated between one and three of those staff on each shift. One of their roles during their shift was to triage all patients including children if no paediatric nurses was on duty. The department had recruited more paediatric nurses since our last inspection in 2018 and was further forward towards meeting this recommendation. They were also holding interviews in the week of our inspection for a senior paediatric trained nurse to lead the service.

All new nursing staff had access to an educational lead who was able to work with them in meeting their competencies and completing their induction to safely meet the needs of patients who used the department. The educational lead also provided training for all nursing staff.

**Medical staffing**

**The service did not always have enough medical staff to ensure safe care was provided at all times due to the layout of the department making patients less visible.**

There were not always sufficient senior doctors on duty at night, given the complex layout of the department, the additional demand from work with COVID-19 patients, and other urgent clinical responsibilities. The rota required there to be one senior doctor supported by three junior doctors at night. This was in line with the recommendations of the Royal College of Emergency Medicine. However, senior staff told us of their concerns. These included the layout of the department made observing patients difficult. The senior doctor on duty could also be required to provide complex treatment at night. For example, providing thrombolysis to stroke patients meant they needed to dedicate a specific time to the procedure when they would be otherwise unavailable to other staff and patients. Consultant cover for the emergency department was from 8am until midnight every day and consultants were on call out of these hours. This met the guidance on consultant cover as recommended by the Royal College of Emergency Medicine.

Due to COVID-19 and the location of the dedicated area to remove personal protective equipment, there were concerns among staff about the response time of the senior doctor should they be required in an emergency. The leadership team at the trust told us if the senior medical staff were going to be with a patient for long periods of time the on-call consultant was called in to cover the department. This was also recorded in the entry on the trust's risk register (see below).

This issue had been reported on the trust's risk register in November 2020. The actions around this included "analysing medical staffing and patient attendance patterns which would help to inform budget setting and planning of medical staff going forward."

The emergency department had two consultants on the rota with qualifications in paediatric emergency medicine. There was an emergency department consultant lead for paediatrics. However, senior staff told us the consultants with paediatric qualification were not allocated specific time on shifts to the paediatric department. This does not meet the recommendations set out by the Royal College of Paediatric and Child Health (RCPCH). This states every emergency department treating children must be staffed with a paediatric emergency medicine consultant with dedicated session time allocated to paediatrics. The department had just under 12 whole time equivalent emergency medicine consultants of which two were paediatric emergency medicine qualified and one was a consultant in emergency medicine with a special interest in paediatrics.

The trust had implemented from the middle of January 2021 a protected paediatric doctor rota between the hours of 2pm to 10pm each weekday where a junior doctor was allocated to work in the paediatric unit. They were working on plans to provide this at weekends.

There was a joint working group comprising of emergency department and paediatric teams focusing on improving the paediatric pathway both within emergency department and the children's ward. Monthly performance review meetings took place where the emergency department performance in relation to the paediatric four-hour targets were reviewed and discussion around the outcomes. Investigations had been undertaken to identify the main causes around any breaches in performance standards around timeliness of treatment.

# Urgent and emergency services

To take charge of the whole consultant-led department, two consultants were rostered on the day and evening shifts who were nominated as the 'emergency physician in charge'. This meant at that times they were recognised as taking overall responsibility for the safety of the department and patient care.

**Records**

**Staff mostly kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care, but some were missing key performance information.**

Most patient records were of a good standard and contained details of medical review and tests requested by medical staff. However, in the eight sets of electronic records we reviewed in detail, four did not have the time the patient was seen by the doctor. This review time is a key indicator of performance and must be recorded.

## Is the service responsive?

**Inspected but not rated**

We did not rate responsive the previous rating of requires improvement remains

**Access and flow**

**Patients could access the service when they needed it but did not always receive care and treatment promptly. Patient handover and treatment-time performance was mostly worse than NHS national standards. However, staff were actively looking for improvements and short and long term solutions, both internally and externally with system partners. In the last year, no patients had been waiting in the department for a decision on their care for more than 12 hours.**

National performance data showed the trust had struggled to achieve the NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours for several years. In the first two months of 2020, prior to the first COVID-19 lockdown at the end of March, the trust only achieved the four-hour standard for 63% of patients. The national average was around 72%. At the trust, this improved in March 2020 to 75% (just below the 76% national average). Performance then improved, as it did at most NHS trusts due to a significant drop in patient numbers, to around 92-96% in April, May and June. It ended the year at just under 70% against the national average of 72%. It was only during the middle of the year where numbers were above the A&E national average but dropped below that level at all other times. In 2020, there were 4,013 patients who attended the emergency department at the Royal United Hospital Bath who exceeded the four-hour waiting time. This was worse than the South West regional average of 3,248 patients.

However, the number of patients waiting between four and 12 hours to admit into the hospital was slightly better than the England average when reviewed over the last six months of 2020. As with most trusts in England and the national average, the number of patients who have waited over four hours had risen. In July 2020, this was 3.4% of those patients who were admitted to a hospital bed at the hospital, and this increased to 22.9% by December 2020. The national average for July was 5.7% and for December 2020, 24.1%.

# Urgent and emergency services

The trust reported no patients waiting over 12 hours for admission to hospital in 2020. Other trusts with a similar number of attendances in the South West reported some patients waiting over 12 hours. The average for the South West for 2020 was around 147 patients each month for over 12 hours but this had risen significantly in the latter part of the year among the COVID-19 emergency.

The department was seeing a high percentage of children within the four-hour performance standard. Performance in relation to the national four-hour standard showed that emergency department achieved 95% in November 2020 and 92% in December 2020 for seeing children. The average performance between April and December 2020 was 93%. This was just below the national standard of 95%.

As reported above, high demand for the services within the trust and bed capacity shortages within the wider hospital meant some patients waited longer to be seen, treated and/or admitted to hospital than expected. During our inspection, 13 patients were waiting in the emergency department for a bed in the hospital. We attended one of the site meetings where senior representation from each directorate was present to discuss flow and bed capacity in the hospital. Staff highlighted the lack of available beds to admit emergency department patients as only 16 patients were planned for discharge across the whole of the hospital. Actions were discussed on how to try to improve the situation such as a further review of patients who might be discharged more quickly.

Leaders were aware of the issues around flow of patients within the hospital and were engaged with the regional escalation plan if capacity within the hospital was highlighted as a concern. A mutual aid plan was available where providers in the region could support each other. The trust told us that they had supported other regions when they had capacity to do so. This enabled the trust to work with the wider network and also access support when they needed it.

The number of patients waiting in ambulances had increased as had delays in patient handovers. National performance data showed the number of ambulances remaining at the hospital for over 60 minutes had increased from 5.4% in September 2019 to 13.2% by September 2020. Data also provided from the trust up to November 2020 showed delays in handovers of patients from ambulance crews to emergency department staff was the second worse in the South West region.

To reduce the number of patients waiting in ambulances, the trust's frailty assessment unit had been allocated as an overflow area while waiting for a space in the emergency department. However, this area was relatively small. We were shown a standard operating procedure which had been agreed between the hospital and the NHS ambulance trust for patients who were waiting within the trust's frailty unit. There was a strict criteria for those patients who were waiting in this area around their safety and risk. Care was provided by two members of the ambulance staff in this area to reduce the numbers of patient waiting on the ambulances.

The trust had recognised the increased delays in the emergency department. Part of the priorities for 2020/21 was to develop direct admission pathways to medical and surgical admission units to reduce delays for patients. At the time of our visit, medical patients that were expected admissions were able to be admitted directly to the medical admissions unit (MAU) if a bed was available. However, due to the current shortage of available beds, it was not always possible to admit expected medical patients directly to the MAU and patients were required to attend the emergency department first.

Staff were working hard to improve patient flow through the hospital. They were coordinating care with other services and providers to access additional beds in the community to improve timely discharges. Trust staff had been working proactively with their own wards and external stakeholders. For example, they implemented an initiative called "20

minutes matters" which is aimed at raising awareness with all staff of the impact a 20 minute delay could have on patient flow. They also were awaiting access to two designated sites in the community where they could discharge patients who needed additional care before going home. Staff told us that these two sites were not fully operational and therefore could not use them yet.

The trust worked with the local out-of-hours service provider on assessing patients for their need to attend an emergency department to reduce the number of attendances. Senior staff in the emergency department were offered additional hours with the out-of-hours team to support with patient assessment as part of a pilot to test this approach to reduce admissions. This took place over two days in October 2020 where patients who would normally be told to attend the emergency department by the out-of-hours service were re-routed to have a clinical consultation over the telephone with a member of these staff from the emergency department. Data provided by the trust showed that out of 70 patients reviewed, only 12 patients were required to attend the emergency department. Senior staff from the trust told us they were working with the local clinical commissioning group (CCG) to develop this process further to reduce the numbers of patients attending unnecessarily.

To provide care and support for patients with mental health needs, the emergency department had access to mental health support 8am until midnight seven days a week.

## Is the service well-led?

**Inspected but not rated**

We did not rate well led, the previous rating of requires improvement remains

**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.**

A new matron and a clinical lead had been appointed for the emergency department in the last two months. They understood and were aware of the priorities and issues the service faced. They were visible and approachable for patients and staff. These new staff felt listened to by the trust leadership team who were supporting the changes and improvements they wanted to bring to the department.

The leaders of the emergency department were developing a vision for what it wanted to achieve and a strategy to turn it into action. These included enhancements to the emergency department's environment and improved working with the local healthcare system. However, plans were still being developed as the new team had only been in post for a short time.

The trust had developed an 'Improving Together' methodology which was centred on quality improvement at every level and communication links from 'shop floor to executive'. The leadership team told us this had improved the understanding of issues within the emergency department specifically. This included recognition of the need to increase and strengthen leadership capacity which had been a challenge due to the clinical commitments of those staff. The trust had identified ways to adequately protect time to enable leaders and teams to progress key work outside of clinical priorities. At the time of the inspection, the emergency department clinical lead and matron told us they were working on identifying additional resources so they could focus on improvement strategies in the department.

The leadership team were focused on improving performance and identifying ways to increase resources to meet demand. For example, the trust provided evidence it had ensured there were enough consultants to provide support to the emergency department. On average between quarter four of 2017 and quarter one of 2020, they had one whole time equivalent consultant above their requirement. The trust also told us that the medicines division (the emergency department was part of this division) had secured funding for two additional whole-time equivalent consultants for the year 2020/21 which would support the department to continue to improve performance and clinical demand.

Feedback from external organisations was positive about the engagement and communication from the trust. We were told by the local NHS ambulance service how the department had been proactive in identifying ways to reduce ambulance handovers and were responsive when there was a high demand in the service. The department had developed a proactive communication plan the ambulance service which detailed escalation plans and key responsibilities once ambulance handovers exceeded 15 minutes.

**Culture**

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

The service had an improved culture and staff felt more valued.

Following a staff survey and a whistleblowing concern in 2019, the trust commissioned an external organisation to undertake a review of the emergency department. The findings and recommendations were shared with all staff through listening events throughout the summer of 2020. Improvements included improved communication from leaders to the department, ensuring leaders were more visible in the department, and recruitment drives. Staff we met told us they felt more supported by the senior staff in the department and they were more visible and accessible.

**Managing risks, 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.**

The staff were able to demonstrate lessons they had learnt from the results of 2019/20 winter planning and had used these to improve the 2020/21 planning. As a result, key priorities had been identified and capital funding had been secured for the emergency department. Improvements identified included improving patient flow through the hospital and reducing crowding in the department. Leaders had identified and escalated relevant risks and issues. They were working on actions to reduce the impact of risks and improve the outcome and experience for patients using the emergency department. They had plans to cope with unexpected events.

Leaders were fully aware of and were engaged with the regional escalation plan if capacity within the hospital was highlighted as a concern. A mutual aid plan was available where providers in the region could support each other. The trust told us that they had supported other regions when they had capacity to do so. This enabled the trust to work with the wider network and also access support when they needed it.

The service had set up a performance dashboard which particularly focused on daily demands and capacity. This enabled managers and leaders to have access to the most up to date information and make decisions effectively in real time. The intelligence from the dashboard was discussed at daily site meetings and reviewed with senior trust staff at bronze, silver and gold command meetings.

# Urgent and emergency services

The emergency department consultant lead for paediatrics was working closely with the trust's paediatric clinical lead on improvement work across both departments. There was a joint working group comprising of emergency department and paediatric teams focusing specifically on improving the paediatric pathway both within emergency department and the children's ward. We saw evidence of monthly performance review meetings taking place. This was where the emergency department performance in relation to the paediatric four-hour targets were reviewed and discussion around the outcomes. Investigations had been undertaken to identify the main causes around any breaches in performance standards around timeliness of treatment. However, an action plan had not yet been developed.

A weekly paediatric bulletin was produced for emergency department staff which included information on the number of safeguarding reviews completed, paediatric attendance in the emergency department and performance in relation to the four-hour standard, medicine management and 'hot topics' for learning.

## Areas for improvement

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

**MUSTS**

**Urgent and emergency care**

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced paediatric nurses to provide safe care and treatment at all times. Regulation 18 (1)

**SHOULDS**

- Review the numbers of senior medical staff on duty, particularly at night, so there are sufficient doctors to manage patients within the complex layout of the emergency department, where they may be less visible, and the need to deal with urgent treatment.
- Review the plan for overcrowding in the emergency department waiting room to consider how to protect patients who cannot wait elsewhere or need protection from adverse weather or who need somewhere to be able to sit down.
- Develop a formal process for the clinical oversight of patients remaining in an ambulance.
- Provide responsive care and treatment to patients attending the emergency department in line with national performance standards.
- Record the time the patient is seen by the doctor in all patient records.
- Provide updated safeguarding training for all staff to meet trust targets.

# Our inspection team

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

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures | Regulation 18 HSCA (RA) Regulations 2014 Staffing |