

The York Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Overall summary

We carried out an unannounced focused inspection of the emergency department at York Hospital on the 13 and 14 January 2020, in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital, however we discussed patient flow from the emergency department. During this inspection we

inspected using our focused inspection methodology. We did not cover all key lines of enquiry. We looked at the safe domain and aspects of both the responsive and well led domains.

Our key findings were:

- Patients who presented to the emergency department with mental health needs were not being cared for safely in line with national guidance (RCEM guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).

Summary of findings

- The department was not meeting the standards from The Royal College of Paediatric and Child Health Facing the future: standards for children in emergency settings.
- Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment exposing them to the risk of harm.
- Systems for recording clinical information, risk assessments and care plans were not used in a consistent way to ensure safe care and treatment for patients.
- We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients.
- Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients.

We found areas for improvement including breaches of legal requirements that the trust must put right. These can be found in the 'Areas for improvement' section of this report.

Following the inspection given the concerns identified a Section 31 notice of decision and 29A warning notice of the Health and Social Care Act 2008 were issued to the trust requiring them to make significant improvements in the quality of healthcare provided.

Ann Ford

Deputy Chief Inspector (North)

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating Summary of each main service

Inadequate



We carried out an unannounced focused inspection of the emergency department in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

During this inspection we inspected using our focused inspection methodology, focusing on the concerns we had. We did not cover all key lines of enquiry.

We found breaches of regulations from previous inspections had not been effectively acted upon. The quality of health care provided by York Teaching Hospital NHS Foundation Trust required significant improvement.

Summary of findings

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York Hospital

Services we looked at Urgent and emergency services

Summary of this inspection

Background to The York Hospital

We carried out an unannounced focused inspection of the emergency department at York hospital in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital, however we did discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry.

We previously inspected the emergency department at York Hospital in 2017 (report published February 2018). We rated it as Good overall.

York Teaching Hospital NHS Foundation Trust provides a comprehensive range of acute hospital and specialist healthcare services for approximately 800,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale - an area covering 3,400 square miles.

The trust's annual turnover is over £0.5bn. The trust manages three acute hospital sites and five community hospitals.

There is a workforce of over 9,000 staff working across the hospitals and in the community.

Each year the trust carries out the following activity:

- 127,000 A&E attendances
- 390,000 outpatient appointments
- 119,000 inpatients
- 61,000 operations and procedures
- 5,000 babies delivered

In total the trust has 46 acute inpatient wards across the three hospital sites at York, Scarborough and Bridlington; 1,006 inpatient beds, 58 day-case beds, 47 maternity beds and 33 children's beds.

The trust also provides outpatient and adult community services providing 1632 outpatient clinics a week from the hospital sites and additional community clinics. The trust operates community inpatient hospital services from four community sites:

- The New Selby War Memorial Hospital
- St Monica's Hospital Easingwold
- White Cross Rehabilitation Hospital
- St Helens Rehabilitation Hospital

Community services for adults including end of life care services are also provided in people's own homes and a range of community clinics across the geography of the trust.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, a CQC inspector, two specialist professional advisors with expertise in urgent and emergency care. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Summary of this inspection

Why we carried out this inspection

We carried out an unannounced focused inspection of the emergency department at York Hospital in response to concerning information we had received in relation to care of patients in this department. At the time of our inspection the department was under adverse pressure.

We did not inspect any other core service or wards at this hospital, however we did discuss patient flow from the emergency department. During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry.

We previously inspected the emergency department at York Hospital in 2017 (report published February 2018). We rated it as Good overall.

Information about The York Hospital

The emergency department (ED) at York District Hospital provides services 24-hours per day, seven days per week. It is a trauma unit and treats level three patients (major and trauma patients).

Staff at the reception desk streamed patients to a number of services including ED, urgent care (run by another provider) and outpatients.

The ED consists of an ambulance assessment area with six cubicles, a resuscitation unit with three bays. The main ED (majors) has 17 cubicles. There is no designated paediatric cubicle in this area.

During the inspection, we visited the emergency department only. We spoke with members of staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with patients and relatives. During our inspection, we reviewed patient records. These included records of mental health patients and children and young people who had attended the department as well as medical and nursing records.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	N/A	N/A	Inadequate	Inadequate	Inadequate
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

Safe	Inadequate 
Responsive	Inadequate 
Well-led	Inadequate 

Information about the service

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Summary of findings

We carried out an unannounced inspection of the emergency department at York Hospital on the 13 and 14 January 2020 due to concerns of crowding and patient care. During this inspection we used our focussed inspection methodology. We did not cover all key lines of enquiry, we looked at the safe domain and aspects of both the responsive and well led domains. We rated these domains as inadequate.

Our key findings were:

- Patients who presented with mental health needs were not being cared for safely in line with national guidance (RCEM guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services).
- The department was not meeting the standards from The Royal College of Paediatric and Child Health Facing the future: standards for children in emergency settings.
- Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment exposing them to the risk of harm.
- Systems for recording clinical information, risk assessments and care plans were not used in a consistent way to ensure safe care and treatment for patients.
- We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients.

Urgent and emergency services

Following the inspection given the concerns identified a Section 31 notice of decision and 29A warning notice of the Health and Social Care Act 2008 was issued to the trust requiring them to make significant improvements in the quality of healthcare provided.

Are urgent and emergency services safe?

Inadequate 

Environment and Equipment

The design, maintenance and use of facilities, premises, and equipment did not keep people safe.

Emergency care settings were not designed or provided to accommodate the needs of children. There was no separation between children and adults in the waiting or assessment areas and there were no designated paediatric cubicles. This was not in line with emergency care standards of the Royal College of Paediatric and Child Health and meant that the department could not be assured children attending the department were kept safe.

The department did not have a suitable area for patients presenting with risk of self-harm. Whilst there was a designated room, staff told us this was often not used due to its location within the department. Neither the designated room nor the preferred assessment cubicle were appropriately decorated, and both had multiple ligature points and furniture which could be used to cause harm including lightweight chairs. This was not in line with standards set out by the Royal College of Psychiatrists in the Psychiatric Liaison Accreditation Network (PLAN) and meant that patients could be at risk of avoidable harm.

Patients arriving at the department by ambulance were not always cared for in a suitable environment. During our inspection we saw that once the ambulance assessment area was full several ambulance crews and patients waited on a corridor situated outside of the emergency department that did not have access to emergency equipment and could not be seen by staff within the department. This was not in line with ambulance handover guidance from NHS Improvement and was a concern because patients arriving by ambulance are at an increased risk if left unassessed, deteriorating patients may not be quickly identified and a potential of delays in diagnosis and treatment created.

Streaming of patients took place at the main reception desk of the department next to patients who were

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booking in on arrival despite two assessment cubicles in the waiting area. This meant there was a lack of confidentiality, privacy and dignity for patients when discussing their symptoms.

The waiting area for the department was shared between several different services such as the orthopaedic clinic, fracture clinic and GP out of hours and meant that patients from each of these services sat together. Patients waiting to be seen in the accident and emergency department could not easily be distinguished. This was a concern because of the difficulty in identifying those at risk of deterioration and posed an infection control risk for all patients including those awaiting orthopaedic review.

Assessing and responding to patient risk

Risk assessments were not always completed in a timely way for each patient, nor were risks removed or minimised.

The median time from arrival to initial assessment was worse than the overall England median over the 12-month period from November 2018 to October 2019. The trust ranged from 18 to 22 minutes compared to the England average of 7 to 8 minutes in the recent six months of national data.

A nationally recognised electronic early warning scoring system was used within the department as well as a written patient safety checklist which included all relevant nursing risk assessments.

During our inspection we found these comprehensive risk assessments had not consistently been completed, or not been completed within the timescales set by the trust for both adults and paediatrics, on 21 occasions of the records we reviewed. We also found two cases where no nursing documentation had been undertaken. This was a concern because these assessment tools were used to identify deteriorating patients quickly and improve patient outcomes including the timely administration of antibiotics and fluids to patients suspected of suffering from sepsis, as well as to ensure important care needs such as fluid, nutrition and pressure care were met.

Staff we spoke to during our inspection raised concerns around the difficulties in completing all the required tasks given the low numbers of staff and felt the safety of the patients was compromised as a result.

Mental health liaison within the department for adults aged 18 and over was available 24 hours seven days a week. Provision for children requiring mental health assessment were available from 8am until midnight.

During our inspection we saw an example of an adult patient waiting for a mental health assessment and found that a risk assessment of suicide or self-harm had not been undertaken, and regular clinical risk assessments were not completed nor documented to explain the reasoning for this. This was not in line with the Royal College of Emergency Medicine core principles of mental health within the emergency department and meant the department could not identify if the patient was at risk of self-harm whilst awaiting mental health assessment.

Mental health practitioners we spoke to during our inspection told us that children who required admitting to the hospital frequently waited long periods of time in the department before being transferred to the children's ward.

The department had adopted a complex streaming model where patients could be 're-directed' following assessment to different areas and services within the hospital. One senior nurse (band six or seven) was allocated to the streaming area each shift and one health care assistant. Staff spoke of the intensity of working in this area and told us that an additional shift was available to staff over and above core shifts to support this area, however was infrequently filled.

Due to the complex model adopted, the streaming nurse was often held up in dealing with one patient causing a back log of others. This was mirrored with the health care assistant who also transferred patients to various areas within the hospital. During our inspection we saw examples of patients at initial assessment not receiving pain relief or clinical assessments such as early warning scores or electrocardiographs (ECG's) in a timely way. We also saw examples of patients including children who were not clinically assessed within the 15 minutes of arrival. This was not in line with the Royal College of Emergency Medicine Initial Assessment in the Emergency Department document or The Royal College of Paediatric and Child Health Facing the Future Standards for Children in Emergency Care Settings and meant the department did not have a robust or reliable process to determine priority or ensure people's safety was appropriately protected.

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We also saw examples of children waiting lengthy periods of time for before they received a medical assessment. Two records that we reviewed during the inspection demonstrated waits to be assessed by a doctor of between two and three and a half hours.

The department did not have a defined process for reception staff to identify or escalate those patients that presented with symptoms which may indicate an increased clinical risk such as chest pain. During our inspection we saw this was reliant on the reception staff recognising such instances rather than a defined set of criteria and because of this, patients were assessed in time order rather than clinical presentation.

There was a dedicated ambulance assessment bay of six cubicles within the department which was to be staffed by two registered nurses and one health care staff 24 hours a day seven days a week. However, during our inspection we found this area to be managed by one registered nurse and one health care assistant. This meant a ratio of one registered nurse to six patients and meant that important early warning scores were not undertaken in line with what the trust specified. There appeared to be no mechanism of escalation based on acuity within this area other than to notify the on-call managers and during our inspection we found ambulance staff queuing with patients in the corridor for up to two hours. At the time of our inspection senior managers told us there was no standard operating procedure for patients arriving by ambulance waiting on the corridor.

Two hourly handovers were undertaken by the physician in charge and lead nurse. Both roles were not supernumerary and as a result the handovers were frequently interrupted and disturbed meaning the time it took to complete the task was greater than expected and impacted further upon important aspects of patient and staff care such as staff breaks and patient observations and assessments.

A sepsis six and dedicated paediatric resuscitation trolley were available within the resuscitation area of the department.

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience which meant there was a risk they could not keep patients safe from avoidable harm or provide the right care and treatment.

Staffing within the department was monitored and set using a baseline staffing tool. However, high turnover and vacancy rates meant that the department was frequently under resourced. During our inspection we were unable to establish the correct number of registered nurses required for each shift as the information we were given by senior leaders differed from the information given by managers and staff within the department and information displayed on patient information boards. We reviewed four weeks of registered nursing rotas and found gaps within each week ranging from one to four registered nurses short per shift. This was mirrored on the day of our inspection when two registered nursing shifts and two health care assistant shifts were not covered and gaps of between two and three registered nursing shifts were short for each adjacent shift. Senior leaders told us that a daily trust meeting took place and staff could be sent to support areas in need however there was no log recorded of staff moves to demonstrate whether this took place.

The department did not meet The Royal College of Paediatric and Child Health emergency care standard of a minimum of two registered paediatric nurses per shift. Nor did it mitigate its failure to meet the standard by for example, evidence of discussions with higher education institutions to ensure training programmes offering child focused knowledge, skills or competencies were available. Profiling when infants, children and young people were likely to attend and focussing paediatric resource at these times nor collaborative or flexible rotation, training or planning with specialist paediatric areas of the hospital where staff could be brought into the department. This meant the department could not be assured the right staff with the right competencies were on duty at the right time. This was identified as a medium level risk in the care group's risk register in April 2018. This was limited evidence of how the care group had managed or mitigated this risk, including no evidence of actual review.

The department used band four associate practitioners to help support the registered nurses within the

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department. During our inspection we saw that these practitioners led the registered nursing handover despite being unregistered and not accredited. This was a concern because important information may not have been appropriately relayed.

Agency and bank staff were utilised to help backfill gaps where possible and were given an induction to the department on commencement of shift. Staff told us that night shifts covered by agency staff were very common. This was consistent with the month of registered nursing rotas which demonstrated that on 17 occasions the night shifts were staffed with three or more agency nurses out of a total of ten registered nursing shifts per night.

The department did not utilise skill mix such as advanced life support or trauma training requirements when allocating the rotas.

Difficulties in filling the registered nursing vacancies sat upon the risk register and senior managers told us the audit tool used to review staffing levels had not responded to the increased demand within the department. A plan to re-run the process again was set for April 2019.

Clinical supervision of staff was undertaken when a serious incident was identified. A clinical supervision policy was being written by the leadership team at the time of our inspection.

Medical staffing

The service did not have 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.

The service did not have enough medical staff to keep patients safe. During our inspection we saw there was a reliance upon locum staff to support the medical rota due to long standing vacancies within the department. Despite this however, The Royal College of Emergency Medicine consultant workforce recommendations of at least 16-hour consultant cover per day was met by the 9.5 whole time equivalent consultants employed, of which three were paediatric emergency consultants.

Medical staff that we spoke to told us they often worked beyond the end of their shift finish times and struggled to get breaks. Junior doctors worked a one in two weekend rota which is the maximum that staff should work according to the British Medical Association.

Staffing was not planned to meet hourly, daily or seasonal variations in demand although a paper to the board was in the process of being drafted at the time of our inspection around the conversion of locum and agency spending to vacancies and work was being undertaken in collaboration with clinical fellowship from another organisation.

Consultant and middle grade recruitment was sighted upon the risk register for the care group with a risk score of 12 (medium risk) and mitigation of the staffing model being under review with a desire to alter the number of doctors per shift within the department. However, this had not been funded at the time of our inspection.

Incidents

The service did not manage patient safety incidents well. Staff did not report incidents or near misses appropriately.

Staff did not always raise concerns or report incidents or near misses in line with trust policy.

The majority of staff we spoke to during the inspection told us they would not report incidents for issues such as staffing shortages. We saw that between the first and 31 of December 2019 of the 70 incidents reported only two related to staffing shortages despite there being staff shortages across a high number of days as indicated from data provided by the trust.

When we analysed the incident reporting data submitted by the trust, we found that of the 70 incidents reported in the department between the first and 31 December 2019, 34 were related to patients arriving in the department with skin damage caused by pressure.

Urgent and emergency services

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Inadequate 

Access and flow

Poor access and flow of patients created significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Patients in the emergency departments at York Hospital were not receiving appropriate care in a timely way, exposing them to the risk of harm.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard over the 12-month period from November 2018 to October 2019.

From January to October 2019 performance against this standard showed steadily increasing median times to treatment. Recent performance has generally been approximately 30 minutes longer than the England average and the standard.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From December 2018 to November 2019 the trust failed to meet the standard and performed much worse than the England average.

Over the 12 months from December 2018 to November 2019, 169 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours in a month were in spring and autumn 2019.

From November 2018 to October 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average.

From November 2018 to October 2019 performance against this metric showed the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment rose steadily from 3.0 to 6.0%, not following the national trend.

From December 2018 to November 2019 the trust's monthly median total time in A&E for all patients was higher than the England average.

From December 2018 to November 2019 performance against this metric showed the monthly total times got longer, not following the national performance.

During our inspection we found repeated examples of poor flow within the department caused by the wider hospital. For example, of the 17 patients who were ready for admission, 14 were ready for transfer but were unable to leave the department due to a lack of capacity in the hospital. The longest wait of these patients was between 15 and 16 hours. From data the trust supplied for the dates 14 December 2019 to 12 January 2020, this indicated that 63% of patients achieved the four-hour standard and 87% of all patients were in the department for up to eight hours.

This in turn impacted upon the time patients waited to be seen, in some cases patients waited six hours in the waiting room. In other cases, the issues with flow of patients through the department and into the wards impacted upon the safe management of deteriorating patients. For example, during our inspection we witnessed a patient suffering a medical emergency in the ambulance assessment area, but they could not be moved and cared for in the resuscitation area because it was full. Two of the patients in the resuscitation area were awaiting medical beds having been in the department for 15 hours and the third waiting for a decision to be admitted. This was further evidenced by delays in discharge from the hospital.

Data from the trust indicated that there were 120 patients with a length of stay of seven plus days and recorded as 'Fit for Discharge' at 16:15 on the 13 January 2020. Of these, 56 were recorded as fit for discharge for over 21 days.

The trust was not meeting the national standards for emergency care, such as the four-hour standard, ambulance handover times, percentage of patients seen within 60 minutes and trolley breaches. Information

Urgent and emergency services

provided to us by the trust demonstrated that between the 6 November 2019 and 18 December 2019, 65% of patients were admitted, transferred or discharged within four hours of attending. The national standard for this is 95%.

We attended a trust bed meeting during our inspection where pressures from the department were discussed. However, there was no representation from the department itself at this meeting and no discussion held in relation to the number of people within the waiting room of the department. This meant this element of patient flow and importantly, emergency department crowding may not have been appreciated, escalated or managed appropriately.

We also saw examples that the department was not appropriately supported by the wider teams within the hospital. For example, we saw a patient in the waiting room assessed by a member of the stroke team and referred for a CT scan. Once assessed this patient was placed back into the waiting room to wait for the scan with the care handed back to the complex streaming nurse who was already dealing with several sick patients. This meant the patient was left unattended in a seated area without monitoring. We also saw an example of a patient being 'returned' to the department after being transferred to a ward and an example of several specialties refusing to accept a critically ill patient within the resuscitation area. Consultants in principle were able to refer patient directly however, in practice this task was not possible due to challenges and resistance from specialty teams at the point of referral. Finally, we saw examples of staff being 'lost' to the ward for up to thirty minutes because beds which were declared ready for transfer were not. This left the department without a member of staff and meant that timely assessments and interventions could be affected. Staff told us that the receiving wards would not come to the department to retrieve the patients, emergency department staff were responsible for transferring them. During our inspection we saw a lack of incident reporting for these concerns.

Of the 22 staff we spoke with at York Hospital emergency department, nine told us that they had raised concerns about patient safety in the department.

Senior leaders told us there was an escalation policy used which we saw in operation within the trust bed meeting, to inform operational pressure escalation levels within the trust however senior staff within the department were not aware of the triggers or actions used to support this.

Are urgent and emergency services well-led?

Inadequate 

Leadership

Leaders were not aware of the risks to children within the service or key issues faced by staff within the department such as a difficulty in taking breaks and managing to fulfil workload.

At trust level the newly formed leadership team were committed and working hard to improve patient safety and care within the department however, had not been in position long enough to have had an impact and were not properly sighted upon key risks within the department such as the risk to children by failing to implement The Royal College of Paediatric and Child Health Emergency Care Standards. They had not yet addressed the concerns raised by streaming clinicians of the pressures faced at the front door nor the lack of support to the department by the wider hospital teams.

Leaders had not effectively acted upon the breaches to regulation which CQC had identified in its February 2018 report in relation to paediatric care and staffing.

There was limited oversight from the trust at board level, at the time of our inspection leaders told us there was no executive sponsor to support the care group.

At the time of our inspection, senior leaders told us there was not a standard operating procedure for patients arriving by ambulance waiting in the corridor and no audit was undertaken to demonstrate the impact upon the patient or the department.

Challenges in addressing the sustainability of both the medical and nursing workforce were recognised however, poor staffing had previously been accepted as the norm. Work had begun to increase the numbers of band six registered nursing roles within the department to retain staff by offering a route of progression. At the time of our

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inspection leaders told us the time scale for this recruitment process to begin was six weeks. Interviews had been carried out for a hybrid patient service operative role. This was a support role which included offering refreshments, stocking consumables and transferring appropriate patients to areas such as x-ray. However, despite registered nurse recruitment being sighted upon the risk register for the care group as a medium risk, (risk score 12) for review in March 2020, the mitigations for this dated back to 2017 rather than more recent considerations. And also included the introduction, in May 2018, of a risk assessment tool as the need for emergency department registered nurses to be redeployed due to pressures elsewhere in the trust were “increasing”.

The local leadership team was also new in post. They told us of their aspirations for the department going forward which included separation of the mutually shared waiting area. However, the newly formed team had not yet had the opportunity to develop a business case for this which would require approval by the trust.

Governance, risk management and quality measurement

Systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not always effective.

Risks identified as breaches to regulations in the CQC inspection report from February 2018 had not been effectively acted upon or mitigated.

There had been no risk assessment or gap analysis of the service against national guidance for key patient groups such as paediatrics or those with mental health needs; this guidance included Royal College of Emergency Medicine (RCEM) guidance, Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services and the Facing the future: standards for children in emergency settings.

We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients within the emergency department, especially in relation to paediatric care.

Departmental staff were aware of the risks in the department, but these were not always reflected on the risk register. This included the lack of suitable accommodation for patients with mental health problems and for children and young people in the department. We reviewed the risk registers sent to us by the trust and found they were not robust with limited assurance of both effective mitigation and dates when actual actions were reviewed.

We saw that there were senior managers in the department during the inspection. They were aware of the situation in the department, but we saw limited evidence of any strategic impact.

We saw during the inspection that not all incidents were reported by staff. This failure to report incidents prevented senior staff being able to investigate any incidents and to spread learning around the department to prevent them happening again and meant escalation of risk and appropriate and timely mitigation of actions did not take place effectively

Culture

Staff satisfaction was poor, and staff did not always feel actively engaged or empowered. Concerns were not always raised, or feedback given.

We saw a poor safety culture and lack of insight around risk management and locally, leaders had not done what they could to actively engage or support staff within the department.

Staff did not feel supported or valued and although all were proud of the work they undertook and worked hard to care for patients many were tired and concerned for patient wellbeing.

Several members of staff we spoke with were actively seeking alternative employment due to what was perceived as the relentless intensity of the workload. Staff appeared to have normalised challenges faced within the department and frequently told us they would not routinely complete incident report forms for key issues such as low staffing levels or missed breaks because it was, they told us, a daily occurrence and they did not receive feedback when they did report an incident. Yet leaders we spoke with felt reassured by the number of

Urgent and emergency services

low scoring incident reports; the main being pressure area damage on arrival in the department and managers told us a mechanism for providing feedback had recently been added to the incident reports.

Work was underway with a national support team to support and develop better communication with the department.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve The Trust must ensure that;

- The flow of patients through the emergency department and the hospital is improved so that patients are assessed, treated, admitted and discharged in a safe, timely manner. Regulation 12(2)(b)
- Patients whose clinical condition is at risk of deteriorating are rapidly identified and reviewed at suitable intervals. Regulation 12(2)(a)(b)
- There are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses especially in relation to paediatrics to meet the needs of patients in the Emergency Department. Regulation 18(1)
- Care must be provided in line with national standards and risks to patients and children attending the emergency department identified, mitigated and effectively managed. 12(2)(a)(b)
- There is an effective system to identify, mitigate and manage risks to patients who present to the emergency department with mental health needs. The system must take account of the relevant national clinical guidelines. Regulation 17(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The regulation was not being met because:

- Access and flow of patients was creating significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. Reg 12(2)(b)
- Patients who presented with mental health needs were not being cared for safely in line with national guidance (RCEM guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services). Reg 12(2)(a)(b)
- The department was not meeting the standards from The Royal College of Paediatric and Child Health Facing the future: standards for children in emergency settings. Reg 12(2)(a)(b)
- Systems for recording clinical information, risk assessments and care plans were not used in a consistent way at York emergency department on the medical wards York Hospital to ensure safe care and treatment for patients. Reg 12(2)(a)(b)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The regulation was not being met because:

- We were not assured that there were sustainable, medium and longer term, plans to ensure sufficient numbers of suitably qualified, skilled, competent and experienced clinical staff to meet the needs of patients. Reg 18(1)

This section is primarily information for the provider

Enforcement actions

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The regulation was not being met because:

- There was not an effective system to identify, mitigate and manage risks to patients who presented to the emergency department with mental health needs. The system did not take account of the relevant national clinical guidelines. Reg 17 (2)(b).
- Not all incidents were being reported and investigated to identify mitigating actions to prevent reoccurrence and reduce the risks to patients.