University Hospitals of North Midlands NHS Trust

Royal Stoke University Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Royal Stoke University Hospital

Requires Improvement  

We inspected the medicine core service and urgent and emergency care service on the 4 October 2022. This was a follow-up focused inspection in response to a warning notice issued in 2021, whereby we notified the trust that the Care Quality Commission had formed the view that the quality of health care provided in relation to medical staffing in urgent and emergency care at the Royal Stoke University Hospital and the risk management of patients with mental health needs medicine at County Hospital required significant improvement.

Medical care (including older people's care)

Inspected but not rated

The inspection took place between 9am and 6pm on Tuesday 4 October 2022 and focused on the care of patients with mental health needs on medical wards, particularly the Acute Medical Unit, Acute Medical Rapid Assessment Unit and Acute Short Stay Unit. We did not cover all key lines of enquiry.

During the inspection we spoke with 26 members of staff, reviewed 15 sets of patient records and 5 medication charts.

We did not rate this service at this inspection. The previous rating of good remains. We found:

- Mental health risk assessments were completed for all patients when admitted to the wards.
- Staff completed and updated risk assessments for each patient and removed or minimised risks when identified.
- Staff on the wards we inspected shared key information to keep patients safe when handing over their care to others.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

However:

- The mental health risk assessment tools were different on each ward leading to inconsistencies in how risks were identified and managed.
- Managers did not always identify training needs or gave staff the time and opportunity to develop their skills and knowledge.

Is the service safe?

Inspected but not rated

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The service had suitable facilities to meet the needs of patients' families. The trust approach was to identify and manage patients based on their individual needs. This was detailed in the observations policy and used on the wards we inspected.

Where patients were identified as a risk to themselves or others, the level was determined and appropriate observations were implemented, including 1 to 1 observations. This was described by staff as the main measure they had to help support patients and manage risk while awaiting specialist mental health support. Sometimes staff were required to cohort patients in order for them to be able to undertake the observations. This meant that a number of patients with a requirement for 1 to 1 observations were sometimes placed together in order to require less staff to undertake the observations. They described occasions when patients had acted quickly and staff were unable to prevent attempts to harm. There were ligature cutters available on each ward and staff had been trained how to use them, however incidents relating to patient behaviours were not always reported. The wards were staffed as planned on most days, however the acuity of the ward fluctuated and at times when there were several patients requiring 1 to 1 observations it left a ratio of 1nurse to 8 or 10 patients on some occasions.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks when identified.

Patients on the Acute Medical Unit, Medical Rapid Assessment Unit and Acute Short Stay were typically transferred from the emergency department (ED), however patients could be admitted directly. When patients presented at ED they were assessed for both physical and mental health and any risks recorded, monitored and mitigated where possible.

There was a formal process in place to enable staff working on medical wards to effectively assess, record and mitigate the risks associated with acute mental health concerns.

Staff completed a mental health risk assessment for each patient on admissionto the ward, and reviewed this regularly.

The trust had created a mental health risk assessment tool which we saw was completed for patients in ED and the document transferred with the patient to the wards. The trust made the decision to have 1 overarching assessment that identified the measures in place across the trust to manage patients who presented at risk of self-harming. The risk assessment was shared with all clinical teams and discussed at the mental health steering group, executive health and safety group quality safety oversight group and through to the quality governance committee and was due for review in December 2022.

We reviewed 15 sets of patient records across three wards: Acute Medical Unit, Medical Rapid Assessment Unit and Acute Short Stay.

We saw completed mental health risk assessments for most patients when admitted to the wards, however, each ward had their own version of a risk assessment tool, which they added to the patient records beside the ED risk assessment. This meant that risks were not easily identified in 1 document and staff did not always know when a patient was a risk to themselves or others. There was not a consistent, trustwide approach.

The Acute Short Stay ward had a 7-day patient risk assessment booklet, which was comprehensive. It included sections such as cognitive impairment, about me, delirium screen, trigger questions, mental health act checklist, safeguarding and checklists for autism, dementia and learning disability care. We reviewed 5 of the booklets and all were completed or commented on to indicate where the assessment was considered but not required. This booklet was used consistently and staff knew where to find the information they required within the booklet.

The Acute Medical Rapid Assessment Unit nursing booklet did not contain any assessment for additional needs but did contain an alcohol screening and referral tool. The ward staff said they referred to the ED risk assessment to check if any risks had been identified.

The Acute Medical Unit nursing assessment document contained a mental health and cognition section in the admission assessment which asked whether the patient had a dementia diagnosis or delirium on admission. It prompted further action if the patient had either of these. It also had a section to complete within the nurse shift assessment for psychological, social, cultural or rehabilitation, however this was not completed in 3 out of the 5 records we reviewed on that ward.

Staff told us that risks identified in ED were not always verbally handed over to the wards, therefore there were some occasions where risks were unknown and therefore not monitored, managed or mitigated. Staff told us of the impact this had on patients and staff by describing incidents that had occurred.

Medical care (including older people's care)

Since our last inspection, the trust had amended their electronic medical records system to include a mental health risk assessment which was to be completed when the patient was reviewed by a member of medical staff. This could not be bypassed, therefore we were assured that an assessment was completed at that stage and all staff had access to this record, however not all staff checked this in the absence of a handover so there was not a shared approach by ED and the wards.

Staff on the wards we inspected shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We saw and staff told us that they provided a detailed handover when patients were transferring from those medical wards to others or discharged into alternative care.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health) and completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, the mental health team would only assess a patient if the ward had ruled out any medical cause. On many occasions this meant that patients with suspected mental health needs and challenging behaviours were being cared for by ward staff in the interim while awaiting test results. This presented risks to patients and staff as they did not have the resource or any additional training to adequately meet the needs of those patients in the absence of specialist support.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

When patients transferred to a new team, there were no delays in staff accessing their records. We reviewed patient records which were comprehensive and easily accessed. The service had transferred all medical records to an electronic system, however nursing notes were still in the transition period from paper to electronic. This did not cause delay in accessing records as any staff could access the electronic record and staff could not identify any time that they have not had access to nursing notes in a timely way.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported most incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The Trust has a policy for critical incident stress management (CISM) support and Royal Stoke University Hospital had access to trained CISM facilitators. However, staff did not always raise concerns, report incidents or near misses in line with trust policy. We were told of several occasions where risks associated with patients with additional or mental health needs had not been handed over from ED and had led to incidents on the wards, however we did not see evidence that these particular incidents were recorded. The trust provided incidents data covering the last three months which did not include the incidents that were described to us by staff during the inspection, however they did include incidents and near misses relating to patients with mental health needs and their behaviours. Staff said that they had come to expect the behaviours that they were regularly subjected to and when they had raised incidents in the past regarding behaviours they had not been taken seriously.

Medical care (including older people's care)

Staff mostly received feedback from investigation of incidents, both internal and external to the service. Lessons learned were fed back to staff through monthly newsletter, Improving Together meetings and handovers.

Managers debriefed and supported staff after most incidents but staff said they did not always receive any feedback following behaviour related incidents nor did they receive any support after the event.

The service acknowledged there has been an issue with the notifications of incidents not being shared with the head of health and safety. This was raised at the mental health steering group and as a result the system had changed so that the matron for mental health and learning disability received all incident reports relating to self-harm directly.

The purpose of the monitoring was to ensure that the measures identified and documented within the risk assessment were effective in managing the risk or whether additional measures were required.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles, however staff told us they needed more training on mental health to make sure they met patients mental health needs.

Staff were not all experienced, qualified or had the right skills and knowledge to meet the needs of some patients with additional or mental health needs. We were told by staff that they did not feel confident or competent to support patients with mental health needs, particularly in the interim when waiting for the mental health team to attend. Some staff told us they had previous experience in mental health or learning disabilities, which was helpful for them, however they were not available for every shift. There was a mental health lead who was dual qualified as a registered general nurse and registered mental health nurse who offered support and advice to staff across the medical wards. Staff said they had increasing numbers of patients with mental health needs and their skills and resources did not provide proportionate support.

Managers did not always identify training needs their staff had or gave them the time and opportunity to develop their skills and knowledge. All staff we spoke with said they would welcome some additional mental health training aside from their mandatory online module, to better equip them to support these patients. They said that the clinical educator was very proactive in advertising any available training and encouraging staff to complete it, however the staff we spoke with had not been made aware of any related to mental health, learning disabilities or dementia.

Leads of the service told us the Psychiatric liaison (MPFT) team had facilitated local training in ED on the County site, providing education on the mental health risk assessment such as how to complete the form and conduct risk assessments. However this was not facilitated at the Royal Stoke site. Additional face to face training sessions had also been facilitated by the matron for mental health and learning disability, delivering mental health training level 1 and a care certificate. This training had been delivered to all newly appointed overseas nurses and nursing assistants, however existing staff said that this was only available for very limited numbers and most were unable to attend.

Medical care (including older people's care)

In June 2022 a mental health conference was organised by the matron for mental health and learning disability. The programme included guest speakers covering specialist topics. The trust provided data showing that 103 delegates attended the session from across the trust.

Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS) training remained through the trust's ELearning platform, however it was planned for monthly face to face sessions to resume in October 2022 across the trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with said they regularly had to make Deprivation of Liberty Safeguard (DoLS) applications for patients, therefore they had good knowledge on how to complete the documentation and knew when this was required. At the time of the inspection there were three patients with restrictions in place, which were appropriate and all documentation was completed and within the patient's records. Once a DoLS was in place, staff followed and reviewed in line with guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The service provided training compliance data which showed that most staff were up to date with their mandatory training, which included a module on mental health and mental capacity legislation. The compliance with mandatory mental health training for the medical division was 84% at the time of the inspection. However, staff said they did not feel this was adequate given the number of patients they cared for on their wards in addition to, the acuity of other patients and would benefit from further face to face training in how to better meet these patients' needs.

There was a registered mental health nurse that they would contact in the first instance if they required advice and they had additional support from the crisis team.

Is the service responsive?

Inspected but not rated

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff were keen to make sure patients living with mental health needs, learning disabilities and dementia, received the necessary care to meet all their needs. Staff explained that they were keen to provide the best care for their patients, however at times they said some patients could have received better care if they had more resources and training to support patients with additional needs, to spend more time with them and potentially prevent some of the behaviours that have occurred on the wards.

Is the service well-led?

Inspected but not rated

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A matron oversaw the provision of mental health and learning disability services within the trust. They were part of a mental health operational group which held regular governance meetings. Relevant aspects from these meetings were escalated to the mental health and learning disability group.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should consider reviewing the mental health training needs of staff so that they are assured they have the skills to meet the needs of patients.
- The trust should ensure that all incidents are consistently reported and investigated, in line with trust policy.

Urgent and emergency services

Inspected but not rated

The Emergency Department (ED) at the Royal Stoke University Hospital is open 24 hours a day, 7 days a week. The trust is a major trauma centre and receives patients by helicopter as well as land ambulance. The helipad where patients were brought in was outside the ambulance entrance. Due to the COVID-19 pandemic and recovery plans from COVID-19, the department had changed the layout. The department now consisted of:

- Six triage cubicles.
- Seven trolley spaces in the ambulance assessment.
- High risk ambulatory with 5 treatment rooms
- Medium risk ambulatory with 4 treatment rooms and 4 trolleys.
- Medium risk majors with 15 cubicles and 1 side room.
- High risk majors with 16 enclosed cubicles and 3 side rooms.
- High risk resus with 8 enclosed cubicles. One bay is set up as a trauma bay and 1 set up for paediatric patients.
- High risk resus with 10 enclosed cubicles. One cubicle was reserved for paediatric patients.
- Children's ED had 1 triage, 1 escalation room, separate waiting rooms (high and medium risk), 4 cubicles, 2 treatment rooms and 3 escalation bays.

During our inspection we had a tour of the new layout of the new children's ED, which is due to open in October 2022.

There is also an urgent care centre located adjacent to the main waiting area. University Hospital of North Midlands NHS Trust ED staff now managed this.

During this inspection, we visited the emergency department only using our focused inspection methodology. We spoke with 12 staff including registered nurses, health care assistants, reception staff, medical staff, and senior managers. We reviewed 8 sets of patient records.

We did not cover all key lines of enquiry just the areas we had identified in the warning notice relating to the emergency department.

We found that the trust had made improvements in staffing and judged that the warning notice had been met. We found the department was working under challenging times when meeting the standards around the 15 minutes from arrival to first assessment. The challenges observed were both around patients who were self-presenting as well as those who were brought in by ambulance. We did not inspect this part of the service during this inspection; however, we did observe the flow of patient arriving to the department. CQC imposed conditions on the trust's registration following an inspection in 2019, because of its performance in assessing patients within 15 minutes of arrival in ED, we are continuing to monitor the trust conditions and conditions remain in place. Our unannounced inspection took place between 9am and 6pm on Tuesday 4 October 2022.

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- The service faced significant challenges on delivering care to meet the needs of local people. People could attend the service when they needed it but faced significant waits for care and treatment.

Urgent and emergency services

- Staff did not always complete the mental health risk assessment proforma tool for each patient arriving to urgent and emergency department with mental health concerns. However, staff were able to identify and seek advice promptly from their mental health colleagues if patients did deteriorate and required mental health support.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, we were not assured medical staff completed all training around capacity and deprivation of liberty safeguards (DoLS).

However:

- The design, maintenance and use of facilities, kept people safe.
- The service had improved around medical staffing requirements following the warning notice which was served in September 2021. The service had plans in place to ensure the department had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available 7 days a week to support timely patient care.

Is the service safe?

Inspected but not rated

We did not rate this service at this time

Environment and equipment

The design, maintenance and use of facilities, kept people safe.

The design of the environment followed national guidance. The department had 1 designated room available for patients attending with significant challenges to their mental health. This room met the specific requirements as advised by the Psychiatric Liaison Accreditation Network (PLAN).

The designated room was placed in a quiet part of the emergency department and close to the Mental Health team. The room had 2 means of exit; doors were fitted with anti-ligature handles and anti-barricade frames allowing for staff to remove the door in the event of an emergency; emergency alarms had been fitted through the room; doors had privacy glass to allow for discrete observations of patients, lighting was adjustable. The furniture such as the chairs and table were heavy and not easy to lift or move.

Assessing and responding to patient risk

Staff did not always complete the mental health risk assessment proforma tool for each patient arriving to urgent and emergency department with mental health concerns. However, staff were able to identify and seek advice promptly from their mental health colleagues if patient did deteriorate and required mental health support.

Urgent and emergency services

Staff shared information to keep patients safe when handing over their care to others. When handing patients over to other departments or wards, staff supported their verbal handover with a written handover document.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff worked closely with the local mental health trust. The department also employed registered mental health nurses (RMNs).

Staff we spoke with told us that pathways for patients with mental ill health had improved since the department employed RMNs, which meant patients were provided with the right support. We reviewed the formal memorandum of understanding in relation to how the services of the urgent and emergency mental health liaison psychiatry service operate in conjunction with the trust. We found the process easy to follow. Liaison psychiatry service are based on site at the Royal Stoke University hospital, the liaison psychiatry service operates 24 hours a day, 7 days a week and operate as per the national standard of 1 hour for urgent and emergency department or 24 hours for Acute Wards.

Patients attending the hospital with physical health and underlying acute mental illness, generally arrived through the emergency department (ED). However, in some cases some patients could be admitted directly to an inpatient ward, which bypassed ED. This did not happen often and followed an agreed process and only when patients were detained under the Mental Health Act at the local mental health hospital. Staff from the mental health hospital attended with the patient and provided all risk assessments, appropriate documentation and necessary care for the patient's mental health needs.

Where patients arrived at ED, it was expected that a mental health risk assessment proforma would be completed in triage for any patient presenting to the department with mental health concerns, such as overdose or self-harm. This proforma was devised specifically to gain a good understanding and assessment of the needs of patients experiencing acute mental health symptoms. Following our previous inspection and enforcement action the proforma had been developed to include a section for ED staff to handover the information to ward staff and for ward-based staff to document that they had understood the handover and the risk assessment.

A trust wide audit was carried out around the completion of the mental health assessment form, which prioritised their 2022/23 clinical audit programme.

The areas highlighted in the audit that needed improvement was:

- Level of risk documented at time of triage to improve.
- Documentation not completed by Doctor and Advance Nurse Practitioners.

The results from the audit covered the below areas:

- Level of risk documented at time of triage (55%)
- Risk matrix documented by doctor / advance nurse practitioner (ANP) (60%)
- Mental capacity assessment tool commenced (27.5%)
- Safeguarding assessments commenced (13%)
- Suicide risk screen commenced (70%)
- Emergency department assessment (doctor / ANP) (77.5%)

- Mental status examination commenced (77.5%)
- Self-discharge form completed for patients leaving the department (3/3)

If a patient was admitted directly to a ward for example following a GP referral, it was expected that the ward staff would complete the mental health proforma.

The guidelines within the assessment tool also aided assessors to consider the risk that the patient may pose to staff members and others. We saw staff in ED were actively completing this tool for those patients who met the criteria. However, during this inspection we reviewed 8 sets of patient records that met the criteria, we found all 8 records were not fully completed.

Shift changes and handovers included all necessary key information to keep patients safe. We attended and observed the department safety huddles meetings, and the discussions held was around current demands within the department and the whole flow of the trust, bed availability and those patients waiting to be discharged. We found the huddles to be robust and well organised.

We found the department was working under challenging times when meeting the standards around the 15 minutes from arrival to first assessment. The challenges observed were both around patients who were self-presenting as well as those who were brought in by ambulance. We did not inspect this part of the service during this inspection; however, we did observe the flow of patient arriving to the department. CQC imposed conditions on the trust's registration following an inspection in 2019, because of its performance in assessing patients within 15 minutes of arrival in ED and submit data to CQC. The trust has been under extreme pressures since 2020 and have continued to submit their conditions data with the CQC.

We reviewed the trust conditions data for September 2022, that showed time to initial assessment for all arrivals within 15 minutes was currently at 67.1%, a drop of 1% when compared to August 2022. The overall performance appeared to show the trust were on an upward trend. The current triage for ambulance arrivals had risen from 70% in August to 72% in September. Triage assessments for walk in patients deteriorated slightly from 66% to 64%.

A new standard operating procedure (SOP) had been implemented jointly with the ambulance trust to keep patients on the ambulances until a trolley was available. Unfortunately, this had been an ongoing system wide issue where there were several ambulances located outside the emergency department waiting to bring patients in throughout the day.

At the start of our inspection on 4 October 2022, there were 8 ambulances waiting to bring patients in. This fluctuated throughout our inspection. Although, staff had received a handover of concerns by the ambulance staff and the patients were under the responsibility of the emergency department, the key performance indicator (KPI) for handover of these patients was recorded from when the patient was finally taken into the department. However, we reviewed the trust latest SOP for management of surges in ambulance arrivals to Royal Stoke University hospital ED. The purpose of the SOP was to ensure a safe and consistent approach in managing ambulance arrivals when there is a necessity to hold patients on the ambulances due to capacity issues in ED. We saw the process around how ambulance crews escalated their patients to staff in ED along with their handover process. All ambulance arrivals were managed through a single entrance of the ambulance arrival doors, ambulance crews supply the receptionist based at ambulance assessment with patients details in order that the patient can correctly be booked on to the system. Ambulance crew provides handover of their patient to the navigator nurse who along with the rapid assessment treatment (RAT) clinician to decide the most appropriate immediate clinical area for each patient. This gave the department an overall oversight of patient waiting to come into the department.

Urgent and emergency services

We saw October 2022 latest data around the ambulance waits outside ED at the Royal Stoke University Hospital, that showed the longest waiting time outside ED was 9 hours and 33 minutes, total of all waits on 27 October 2022 was 196 hours, 70 patients were delayed with an average wait of 2 hours and 48 minutes. Clinical staff communicated closely with the ambulance crews; and doctors from ED were allocated to assess those patients on the back of the ambulance vehicles to ensure patients were being reviewed and risk assessed on a regular basis, those at high risk would be urgently prioritised.

Nurse staffing

The service continued to have challenges around nurse staffing, the service had plans in place to ensure the department 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 staffing levels and skill mix, and gave bank and agency staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The manager could adjust staffing levels daily according to the needs of patients.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service did not always have enough nursing and support staff; however, since the 2021 inspection, the department had made significant improvements around nurse recruitment. The department was budgeted for 343.63 whole time equivalent (WTE) nursing and healthcare assistants, an increase from 223.89 WTE in 2021. However, information showed the department currently had 332.85 WTE staff in post, leaving a vacancy rate of around 3%. The trust are actively recruiting for nurses.

The service met the Royal College of Paediatrics and Child Health (RCPCH) standards of ensuring there was always at least 2 registered children's nurses on every shift. Staff told us they tried to ensure there were at least 4 registered children's nurses on each shift. Senior staff told us recruitment was a rolling process which is managed by the education lead. However, during the 2021 inspection, senior staff told us they were hoping to bring this back into the senior nurse's responsibility to review staffing levels and recruitment as well as being able to communicate with the ED team better about staffing going forward, however this had not happened and the education lead still managed staffing.

Medical staffing

The service had plans in place to ensure the department had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix. Managers gave locum staff an induction when present for shifts.

Following the 2021 inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to medical staffing within the department. We received the trust improvement plans and we were also informed the trust had successfully secured its business case to recruit and increase its medical staffing. We carried out an unannounced focused inspection specifically to the 29a warning notice. We found the trust had made significant improvements and assured the trust had met the requirements.

The department was budgeted for 157.34 whole time equivalent (WTE). However, information showed the department currently had 152.54 WTE staff in post, leaving a vacancy rate of around 3%.

Urgent and emergency services

The trust provided us with a comparative of the changes in budget and vacancy for the ED medical workforce from the previous CQC inspection in August 2021 and October 2022. Which identified that the trust had recruited an additional 31.73 WTE medical staff.

Since the 2021 inspection, the trust had implemented the tiering medical and practitioner staffing in ED based on the Royal College of Emergency Medicine (RCEM) 2015 guidance. The workforce in the RCEM document is divided into 5 tiers. The trust latest tiering work group within the emergency department comprised of:

- 17.27 WTE consultants plus 3 locum consultants and 4 military consultants ranging between 0.6 and 0.9 WTE (24.54 budget)
- 18 Foundation doctors
- 5 Acute Care Common Stem (ACCS) is a three-year core training programme enabling Foundation programme trainees to embark into a career in emergency medicine (EM), anaesthetics, intensive care medicine (ICM) and acute medicine (AM).
- 5 *GP* vocational training scheme (GPVTS)
- 7 Specialty trainee 3 (ST3) is a point at which subspecialty training is commenced and usually attracts a national training number and is equivalent to the previous junior registrar.
- 7 higher specialist trainees (HST 4)
- 1 Paediatric Emergency Medicine (PEM) speciality trainee
- 2 Specialty and Associate Specialist (SAS) doctors. SAS fill NHS service roles which sit outside of the Specialty Training pathway. These roles are non-training 'service' roles where the doctor has at least four years of postgraduate training, at least two of those being in a relevant specialty.
- 20 Certificate of Eligibility of Specialist Registration doctors (CESR). Is a means by which *doctors* who have not completed an approved deanery training programme can be entered on the Specialist Register.
- 3 clinical fellows
- 38 Junior Training Fellows
- 21 Advanced clinical practitioners (ACPs) in post, with an additional 15 recently recruited. ACPs are healthcare professionals, educated to master's level or equivalent, with the skills and knowledge to allow them to expand their scope of practice to better meet the needs of the people they care for.
- Multiple GPs with a speciality interest in Emergency Medicine.

Senior staff told us that 122 staff (and their anticipated new ACPs) were provided with an educational supervisor, with some middle tier doctors providing educational supervisors for junior training fellows on completion of the training the trainer course.

The service always had a consultant on call during evenings and weekends. There was a trauma team leader onsite throughout the evening with an additional consultant on call for telephone advice if required. Although the consultant on call was not required to attend in person, senior staff told us if the department required additional support, they would attend.

Urgent and emergency services

We reviewed the medical staffing rota and found improvements around the skill mix and establishment of shift covering. We saw 449 vacant shifts for September, of which 382 gave a fill rate of 85%, 355 were filled by bank doctors, with 27 filled by agency doctors.

Rota cover overnight according to the RCEM guidance is to have 2 ST4 and above for overnight duties. The trust overnight rota template is based on 3 middle tier doctors, with 2 of which should be ST4 or above and the third an ST3, CESR or clinical fellow. We reviewed overnight rota for August 2022 to October 2022 and identified the number of ST4 or above were on shift overnight, of which were Red, Amber and Green (RAG) rated; Out of 70 shifts, 55 green rated, 5 amber rated and 10 red rated.

Is the service effective?

Inspected but not rated

We did not rate this service at this time.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

The service had dedicated support for patients diagnosed with a psychiatric condition or experiencing symptoms of poor mental health based at Royal Stoke and County hospital. Staff could refer to a dementia liaison team to support patients living with dementia. These teams were delivered and managed by the local mental health trust covering the area.

Staff could contact psychiatric support at any time of day or night through the local mental health hospital. Staff told us that the psychiatric liaison team were very responsive to requests for support.

The trust worked with partner agencies to support patients who attended ED frequently. Partner agencies met at a high-volume user meeting which included trust staff, mental health colleagues and staff from the ambulance service. This meeting discussed HVU of the service and investigated cases; where individuals are utilising emergency department of the trust at a higher volume than expected of the Stoke and North Staffordshire population. We saw examples of team working and patients being at the centre of care.

The ED used a standard operating procedure (SOP) process for management of intoxicated patients with mental health needs. The purpose of the SOP was to outline the process for the management of patients that attend ED, who are intoxicated with underlying mental health needs that are suitable for assessments at another service. These patients can self-present, conveyed by ambulance or the police. This SOP supported those patients that did not require to be in ED and should be placed in a more suitable environment for their individual needs.

Urgent and emergency services

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, we were not assured medical staff completed training around capacity and deprivation of liberty safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us the training they received around mental capacity had enabled them to develop the knowledge and competence to identify when a patient may be lacking capacity and how to assess the patient.

We saw the compliance for all clinical staff within ED around mental capacity and consent training was variable and ranged between 33% and 100%. This meant that the trust did not always meet its target of 85%.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should ensure that all mental health patients presenting to emergency department have their mental health risk assessment proforma tool completed and kept with patient should they be transferred to other departments of the hospitals.
- The trust should ensure all staff complete relevant training around mental health awareness, including mental capacity and deprivation of liberty safeguards (DoLS).

Our inspection team

The team that inspected the service comprised of CQC inspectors, specialist advisors with expertise in urgent and emergency care, medicine care and mental health.

The inspection was overseen by Sarah Dunnett, Head of Hospital Inspection.