University Hospitals of Leicester NHS Trust

Leicester Royal Infirmary

Inspection report

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Ratings

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

Our findings

Overall summary of services at Leicester Royal Infirmary

Requires Improvement 

We carried out this unannounced focused inspection of both the urgent and emergency care and medical care core service because we had concerns about the quality of services in these core services. These concerns included waiting times for patients, delays in their care and treatment, delayed discharges, and delays in being able to hand over patents waiting in ambulances. We also checked the quality of services in response to a warning notice we issued following our inspection of urgent and emergency care in January 2020.

During this inspection we inspected the urgent and emergency care and medical care core services using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have re-rated some key questions based on the findings from our inspection. We rated both these core services as requires improvement. Overall, we rated safe and responsive as requires improvement in both urgent and emergency care and medical care services. We did not rate the effective, caring or well led domains.

Our rating of urgent and emergency care services stayed the same. We rated it as requires improvement and have taken enforcement action as a result of this inspection to promote patient safety. We served a warning notice to the trust requiring them to make improvements to their urgent and emergency care services, to address safety concerns in respect of staff deployment, flow in, through and out of the emergency department, timely and consistent medical in-reach processes, privacy and dignity, clarity in respect of clinical responsibility when patients were referred to speciality services and triage processes.

We did not inspect surgery, services for children and young people, outpatients or diagnostic imaging previously rated requires improvement. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

We had an additional focus on the urgent and emergency care pathway across Leicester, Leicestershire and Rutland and carried out a number of inspections of regulated services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

A summary of CQC findings on urgent and emergency care services in Leicester, Leicestershire and Rutland.

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

Leicester, Leicestershire and Rutland

Provision of urgent and emergency care in Leicester, Leicestershire and Rutland was supported by services, stakeholders, commissioners and the local authority.

Our findings

We spoke with staff in services across primary care, integrated urgent care, acute care, mental health services, ambulance services and adult social care. Staff had worked very hard under sustained pressure across health and social care services.

People reported difficulties when trying to see or speak to their GP. Some GP practices had invested in new technology to improve telephone access. Staff working in GP practices signposted patients to extended and out of hours services to prevent people attending the emergency department whenever possible.

Staff working in urgent care reported an increase in demand and an increase in acuity of patients presenting to their services. Some staff reported frustrations in relation to urgent care pathways; staff working in advanced clinical practice were not always empowered to make referrals into alternative pathways.

Staff working in urgent care services reported challenges due to the volume of pilots focused on admissions avoidance running across Leicester, Leicestershire and Rutland. Many pilots ran for relatively short periods of time and were often impacted by staffing issues. This made it difficult to maintain oversight of pathways available to avoid acute services. However, some pilots had proved successful and prevented ambulance responses and hospital admissions.

Staff working across urgent and emergency care services raised concerns about their skills set. Some ambulance staff feared the shift from dealing with multiple emergencies to providing longer term care for one patient in a shift, in combination with having less time for training, impacted on their competency. Some staff in urgent care services felt they needed additional training to meet the needs of patients presenting with higher acuity.

Patients seeking advice from NHS111 in Leicester, Leicestershire and Rutland experienced some delays getting through to the service, when compared against national targets. However, at the time of our inspection, performance was better than England averages for key indicators including the percentage of calls answered within 60 seconds, and call abandonment rates. Staffing continued to be a challenge across NHS111, however recruitment was on-going.

Out of hours care had been challenging throughout the pandemic as staff were redeployed to other key services, this had particularly impacted on home visiting services.

The emergency department serving Leicester, Leicestershire and Rutland is within a large, city centre hospital. and poor patient flow across health and social care has further increased the significant pressure on the emergency department. This pressure has resulted in long delays in care and treatment. Long delays in ambulance handovers have, in turn, resulted in a high number of hours lost to the ambulance service whilst their crews wait outside hospital. This causes further delays in responding to 999 calls to patients in the community with serious conditions.

Ambulance crews reported an increase in the volume of patients calling 999 who told them they had been unable to see their GP and crews often signposted patients back into primary care.

We found psychiatric liaison services at the city centre hospital were well run and designed to meet people's needs. Staff demonstrated effective partnership working with a person-centred approach and good use of alternative pathways to avoid admission into acute or social care services.

We found that staff working across specialisms in acute services did not always provide sufficient in-reach into the emergency department to improve patient flow and the care received. This was particularly apparent at night. Beds

Our findings

were not allocated to patients until they had been accepted by specialists, this meant some patients spent additional time waiting in ED. During our inspection, between 45 and 60 beds were needed for new patients waiting in ED. Some patient transfers to other hospitals in Leicester, Leicestershire and Rutland stopped at 8pm, this restricted patient flow out of the city centre hospital.

Some staff reported frustrations with escalation processes across health and social care in Leicester, Leicestershire and Rutland. At times when the city centre hospital and the ambulance service was under significant pressure, staff felt there was a lack of diverts available to other sites or services and that system partners were slow to respond. There was a rapid ambulance handover process when services were in escalation; however, staff reported these were not effective.

There was a high number of patients in hospital who were medically fit for discharge but remained in acute services. System stakeholders worked together to consider discharge pathways; however, at the time of our inspections the number of patients awaiting discharge remained very high. Delays were still commonplace and capacity in community and social care services impacted on the ability of staff to safely discharge patients. Communication about discharge and discharge processes were impacting on the quality of transfers of care to social care services.

People living in a social care setting experienced long delays, particularly when accessing 111 or 999 services. Although advice was provided, this had resulted in significant waits and poor outcome, especially for people who had fallen and remained on the floor. Staff working in social care services told us they had limited access to support and advice and relied on GPs, 111 or 999.

System wide collaboration, accountability and risk sharing needs to improve to alleviate pressure on key services in Leicester, Leicestershire and Rutland

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

- The service did not always have enough staff to care for patients and keep them safe. Patients risks were not always assessed, and medicine administration was not always carried out in a timely manner which had the potential to cause patient harm.
- Patient care, treatment and access was impacted by the lack of medical review processes within urgent and emergency care services.

However:

- Local leaders and managers had the right skills and abilities to run the service and were visible to staff. They supported staff to develop their skills and take on more senior roles.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

How we carried out the inspection

During our inspection we spoke with 70 staff, of various specialty and profession including consultants, doctors, nurses, pharmacists, healthcare support staff, matrons, and senior managers. This included interviews conducted after the inspection visit on site.

Our findings

During our inspection we visited the GP assessment unit, acute frailty unit, Acute Medical Unit (AMU), discharge lounge, the stroke ward 26, older people's wards 23 and 29, wards 33 and 34 and ambulatory care. We visited all areas of the emergency department.

We spoke with 24 patients and reviewed 48 patient records, including additional electronic versions.

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

Urgent and emergency services

Requires Improvement ➔➔

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

- There were delays in moving patients off ambulances into the ED and in triage when the department was full. This resulted in delays in assessment and treatment for some patients. Patients admitted to the department had some of their risks assessed and updated.
- People could not always access the service when they needed it and did not always receive care promptly. Specialists did not always review their patients in ED within agreed timescales which increased blockages in the department and delays to treatment. Poor hospital flow led to delays in accessing hospital beds for patients who required an admission.
- There were nurse vacancies in the emergency department (ED) and on some days, not all services operated fully due to staffing shortages. During our inspection the risks associated with gaps in the rota had some mitigation. The ED did not always have enough nursing staff with the right qualifications, skills, training and experience which increased the risk of patients suffering avoidable harm.
- There were not enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at all times. More consultants were required to run the department safely when it was overcrowded. Patients waited a long time to see a senior decision maker.
- Due to high demands on the service, and excessive capacity pressures, the premises did not always keep people safe. There was insufficient space to accommodate all the patients in the department and some rooms were unsuitable for the purpose they were being used.

However:

- Local leaders and managers had the right skills and abilities to run the service and were visible to staff in the emergency department (ED). They supported staff to develop their skills and take on more senior roles.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Is the service safe?

Requires Improvement ➔➔

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. Staff knew how to make safeguarding referrals and who to contact if they had concerns about patients. Children identified as being at risk while in the emergency department (ED) were referred to the trust safeguarding team and to the local authority appropriately. There was a system to flag up known concerns about children and families.

Urgent and emergency services

Children and adults who left without being seen were reviewed and if necessary, followed up by GP notifications.

Staff had training on how to recognise and report abuse and they knew how to apply it. All staff we spoke with said they had received safeguarding training at a level appropriate to their role. Most nurses were trained to level two adult safeguarding and level three children safeguarding. This was in line with national guidance for nursing staff in emergency departments.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Some areas of the department included non COVID-19 patients and possible COVID-19 patients in close proximity.

Once patients were admitted to the department, staff took appropriate actions to prevent the transmission of COVID-19 and other infections. There was a designated area for patients who presented with COVID-19 symptoms or had tested positive for COVID-19. Most patients were treated in single cubicles with glass fronted doors, except in the ambulatory area and the resuscitation rooms which were fully enclosed. Suspected COVID-19 Patients who arrived by ambulance were taken to a designated waiting area until an appropriate space in the emergency department (ED) became available.

The waiting area for walk in patients was separated by portable screens which attempted to keep patients who may have COVID-19 or other infections, separate from those who were unlikely to have COVID-19. Throughout our inspection, these screens had been pushed aside by patients and their relatives who wanted more space. It was difficult for staff to always supervise the screens.

Confirmed COVID-19 cases and those with other highly infectious conditions, or highly vulnerable patients were allocated to a cubical on arrival, subject to availability. This was on the service risk register.

All areas within the ED were visibly clean and had suitable furnishings which were mostly well maintained. Furnishings, such as chairs and flooring were wipeable and easy to clean.

Managers audited staff compliance with infection control practices including hand hygiene, use of personal protective equipment (PPE) and cleaning. Compliance was reported to the infection prevention and control team and reported in the matron's quality reports. Audit results showed staff were following infection prevention and control guidance and that the ED environment was kept clean and tidy.

Staff mostly followed infection control principles including the use of PPE. Staff were bare below elbows for effective handwashing and always wore surgical masks. Staff wore disposable gloves and aprons, most of the time when required, for example when assisting patients with personal care. Not all staff wore aprons when cleaning bed spaces and some staff wore aprons for multiple tasks without changing them. Hand hygiene sinks, hand gel and PPE were available throughout the department.

Staff cleaned patient equipment after each patient use. Equipment not in use was stored cleanly. Some equipment was stored in patient bed areas and was assessible to patients. There was a risk this equipment could become contaminated between patient use. Some equipment had stickers with cleaning dates recorded.

Urgent and emergency services

Most staff had in date infection prevention and control training and all staff told us they had received updated training in donning and doffing PPE during the COVID-19 pandemic. Staff compliance with IPC training was monitored across the ED.

Rapid tests were available for COVID-19 and all patients were asked screening questions on arrival to ED. There was a policy for staff to test themselves for COVID-19 twice a week. This was not recorded by the hospital although matrons were assured guidance was followed as COVID-19 positive staff were routinely identified during this process. All staff had been offered COVID-19 vaccinations and boosters in line with national guidance.

Environment and equipment

Due to high demands on the service, and excessive capacity pressures, the premises did not always keep people safe. There was insufficient space to accommodate all the patients in the department and some rooms were unsuitable for the purpose they were being used.

The design of the environment mainly followed national guidance but the size and layout of the department did not meet the needs of all of the patients requiring access to the service. Guidance contained within the Health Building Note 15-01; Accident and Emergency Departments planning and design and the 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care was largely followed. However, due to the reconfigurations carried out as a result of COVID-19, some areas of the ED were not suitable for the purpose they were being used.

The adult and children's emergency departments (ED) were physically separate departments and were purpose built in 2017. Since this time several reconfigurations had taken place. The environment inside the ED was light and spacious and most patient cubicles were fully enclosed single rooms.

We inspected two rooms where more than one patient received care at the same time. One room was used to monitor cardiac patients and contained two beds, separated by curtains. The room was used for both male and female patients at the same time and was located away from the nurses' station and out of view from the main area. The room also contained open shelving with lots of equipment, including neck braces and walking frames, which could get dirty or cause a trip hazard.

A small room in the ambulatory area was used to sit up to four patients on reclining chairs. This room was not designed for overnight use. During our inspection, three patients were always in the room and patients stayed there for excessive periods of time and overnight if necessary. During our inspection one patient had been in one of the reclining chairs for 18 hours. The room also contained storage cupboards and patients told us nurses had accessed these frequently during the night. Patients were on different treatments while in the room, including oxygen and intravenous (IV) therapies. Patients told us about the increased noise levels, including IV machines bleeping and nebuliser therapy. However, the patients we spoke with all told us they would rather be treated in the room than kept waiting out in the main ED waiting area. There was a standard operating procedure (SOP) for the use of this room which contained admissions criterion for patients allocated here. However, this was under review at the time of our inspection and had had not been ratified, we were therefore unable to review it.

There were insufficient treatment and assessment areas to accommodate all the patients attending the department. Patients were frequently held on the back of ambulances until a bed became available. However, no patients were cared for in the ED corridors. There were not always enough triage rooms to triage patients at a rate the staff wanted, or within guideline timeframes.

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When the waiting area was busy, it was difficult to follow social distancing, including for patients sitting in the 'possible COVID-19 area'. Patients were asked to attend alone if possible, however family members were permitted to accompany patients when necessary.

Walk in patients were booked in at the main reception area. There were several reception staff on duty day and night. The reception desk was an oval space with seating for booking in staff and a visual assessment clinician (VAC nurse). Patients queued prior to presentation at the reception desk. Patients were advised to stand back and footprints on the floor guided patients to where they were required to stand to improve privacy.

After booking in, patients saw the VAC nurse and were asked more details about their condition. Due to the layout of the department, it was possible these conversations were overhead by other patients waiting. However, attempts had been made to limit this since our last inspection and more space was allocated behind patients while they received their VAC assessment. Privacy at the front desk and during the VAC assessment had been raised in the two previous inspections of the department and it remained on the ED risk register.

The injuries area was in a different area to the main ED. Patients who attended with suspected minor injuries were sent to the minor injury's unit. The signposts to and from injuries area were difficult to follow. The injuries area was not purpose built and lacked piped oxygen and wall suction, although portable versions were both available in the department. The patient trolleys were spread out over several rooms, which were difficult to observe and most of which also contained large amounts of storage including sterile dressings and equipment cupboards. These were not locked and were open to tampering or theft.

There was enough suitable equipment in the emergency department to help staff safely care for patients. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the emergency department. Daily safety checks of specialist equipment had been carried out on most days.

Clinical waste was disposed of safely using separate designated waste bins for general and clinical waste and sharps buckets for sharp instruments were available throughout the department.

Assessing and responding to patient risk

There were delays in moving patients off ambulances into the ED and in triage when the department was full. This resulted in delays in assessment and treatment for some patients. Patients admitted to the department had some of their risks assessed and updated.

Patients who arrived by ambulance when the ambulance assessment area was full remained in the care of the ambulance service until they were handed over to the emergency department (ED) staff. The hospital had clinical responsibility for these patients. Patients waiting more than 30 minutes in an ambulance were assessed by an advanced care practitioner (ACP) and monitored regularly by ambulance staff.

ACPs did not always have the necessary skills and experience to appropriately assess the seriousness of every patient presenting in an ambulance. ACP's told us they had concerns about doing their assessments in the back of an ambulance, and consultants told us they had concerns that some seriously ill patients may not be allocated the correct priority score without a review by a senior decision maker on arrival. There was a concern amongst ED consultants there may be missed opportunities to identify deteriorating patients rapidly without a senior ED medical review. The ACP had access to medical staff working in the department if they were concerned about a patient. Senior medical staff were not

allocated to assess patients on ambulances due to a lack of senior medical staff in the ED. ED doctors told us they were concerned about the safety for patients waiting in ambulances a long time and this was on the service risk register. Mortality and morbidity meeting minutes discussed a case where the patient assessment on the ambulance had been done by an ACP and where a senior decision maker may have prioritised the patient differently.

Guidance from Royal College of Emergency Medicine (RCEM) recommends patients should be offloaded from ambulances within 15 minutes of their arrival at ED. Trust board papers from February 2022 reported that 24% of ambulances waited more than an hour to offload in December 2021. On 8 April 2022, 57% of ambulances waited over an hour to offload and from 21 March to 18 April 2022,1548 patients waited more than an hour in an ambulance. On 11 April 2022, at 8pm, the longest ambulance delay was four hours and six minutes. The average time for patients to stay on an ambulance when arriving at this ED in April 2022 was 112 minutes. It had been over 70 minutes every month since October 2021.

ED staff previously conducted harm reviews for patients delayed on an ambulance for more than 30 minutes and later adjusted this to delays of 120 minutes. They concluded there had been no incidence of significant patient harm for these patients and consequently, harm reviews were stopped for this group of patients. Instead, harm reviews were undertaken on all patients in the ED who had been waiting a 'long time'. Senior nurses told us they had identified several harms to patients in this group, including an increase in the number of patients that have sustained level 2 or 4 harm as a result of a fall in ED. Actions instigated to address this included: Booking healthcare staff to care for vulnerable patients on a one to one basis; the introduction of ward based matrons to the ED to ensure the ongoing needs of individual patients were identified quickly; and new patient chairs in each area which allowed patients to sit out of bed to prevent deconditioning and maintain patient strength.

Concerns regarding long delays in ambulance turnaround times were raised with the trust in November 2019 and the trust produced an action plan to improve flow in ED. However, this had little impact, and long delays were still a problem for many patients. Trust board minutes from February 2022 identified hospital flow and delays in discharging medically fit patients as a key issue in preventing improvements to ED performance. On 11 April 2022 at 9pm, 55 patients were waiting in ED for a bed to become available within the hospital. At the time, there were no beds available although senior managers told us some of these patients would be admitted to a bed that night.

Walk in patients were not always assessed or given treatment in a timely manner. Standards set by the RCEM state an initial clinical assessment should take place within 15 minutes of a patient's arrival at hospital. From 22 March to 18 April 2022, between 64% and 23% of patients were triaged within 15 minutes of arrival. On most days, less than 40% of patients were triaged within 15 minutes of arrival.

During our inspection we saw some delays to triage. The longest wait on 11 April 2022 at 9.15pm was two hours. Children triages were also delayed. For example; on 1 January 2022, 135 children's assessments were carried out, and only 39% were carried out within 15 minutes of arrival and on 15 March 2022, 196 assessments were done and only 26% were within guidance. Compliance on most days from 1 January 2022 to 25 April 2022 was between 50 and 60%. A lack of nursing staff and not enough clinical triage rooms had been identified as a cause of the increasing delays to triage. Delays to triage was on the service risk register.

Some of the risks associated with delays to triage and assessment of walk in patients in the ED were slightly reduced by checks undertaken by the visual assessment clinician (VAC nurse). The VAC nurse had the first point of clinical contact with patients and were responsible for assessing the patient appropriately and streaming them to the correct area for a full assessment and treatment, according to their presenting complaint. Patients were streamed to the ambulatory care area, or minor injuries clinic for example.

Urgent and emergency services

The VAC nurse allocated each patient a dynamic priority score (DPS). DPS scores were one, two or three, with one being the most urgent. Most walk-in patients were categorised as DPS two or three, and were seen in order of DPS priority, and time of arrival. However, the DPS score did not mitigate the risks of delayed triage, especially when there were insufficient nurses to offer timely triage to all patients trying to access the service. Some patients had delays in their VAC assessment. For example, on 28 March 2022, 117 patients waited more than 30 minutes and a further 47 waited more than 47 minutes which accounted for 21% of all patients awaiting a VAC assessment. Patients whose condition worsened while waiting may not be seen quickly enough because they had been allocated a lower priority DPS score. Delays to immediate treatment may lead to a rapid deterioration in some patient's conditions leading to poorer outcomes for patients. ED staff were aware of this risk which had been discussed in relation to a patient death highlighted in the mortality and morbidity meeting minutes in March 2022.

To reduce the risks of patients waiting for triage after their VAC assessment, most patients had a full set of observations undertaken in the waiting room by another healthcare professional and following which they had an early warning score calculated. During our inspection, there was a member of staff allocated to carrying out patient observations in the waiting room some of the day.

Senior staff reduced the risks associated with delays to triage by allocating only senior (band six and above) nurses to the VAC role, and also by having experienced senior nurses working in triage. This helped identify the sickest patients, or those most at risk of rapid deterioration, as soon as possible. However, this had been recognised as a risk to staffing in other areas of the ED, where experienced nurses were also required for their skills in looking after seriously ill patients.

Adult patients were assessed using the National Early Warning Score (NEWS2) as recommended in guidance from the National Institute of Health and Care Excellence (NICE), Clinical Guidance (CG) 50: 'Acutely ill adults in hospital: recognising and responding to deterioration' (2017). The NEWS2 determined the degree of illness and was based on the patient's vital signs, including respiratory rate, oxygen saturation level, blood pressure and heart rate. The score was highlighted on the initial assessment as an early warning score (EWS) which helped to identify patients most at risk of deterioration or sepsis. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs and action is required quickly.

Patient observations were recorded electronically in all areas of the department. The electronic track and trigger system (e-observations) calculated the EWS scores and set frequency of observations and any escalation response. Most patients had their repeated early warning score carried out appropriately and in line with frequency guidance, however we saw some patients whose repeat monitoring was delayed. This included a patient with an EWS of 10 waiting more than hour before the next set of observation were recorded, and another patient with an EWS of nine, waiting nearly 90minutes before the next set of observations were recorded. Higher EWS required more frequent recordings. For example, an EWS above seven required repeat observations every 15 minutes. Staff said the risks to these patients were minimised due to their high visibility in the department, and that despite delays in recording observations for some patients, patients were regularly being checked and monitored by staff.

A large visual display unit listed each patient's EWS along with the time the next set of observations were due. Any delayed observations were highlighted in red for all staff to see. Senior nursing staff were aware there had been some delays in repeat observations and had increased the number of healthcare staff to reduce delays. There had been no incidents of harm reported as a result of delayed observations and failures to recognise deteriorating patients. Medical staff were aware of EWS and nurses escalated changes appropriately. Audits on timeliness of EWS were not undertaken in the ED.

Urgent and emergency services

Nurses and medical staff were aware of recognising sepsis and we saw no delays to treatment for suspected sepsis patients during our inspection. Sepsis treatment and recognition was audited in ED. Results for March 2022 showed 21 patients out of 226 patients, waited more than three hours for their antibiotics. Compliance with antibiotic administration within one hour for March 2022 was 62%. This was similar to the monthly compliance from April 2021 to February 2022. The trust shared three incidents from January 2022 to April 2022, including one resulting in moderate harm, where patients in ED had not received sepsis care in line with trust policy or national guidance. Reasons for this were recorded as lack of review by speciality team, and/or an overcrowded ED.

The trust had a policy which required venous thrombus embolism assessments (VTE) to be carried on all patients in the ED if they had been there for more than 14 hours from their time of arrival. We did not see any VTE assessments undertaken in the patient records we looked at when patients had been in the department for over 14 hours. The trust were aware of low compliance with VTE assessments and had carried out a risk assessment on the likelihood of harm for patients of not getting an assessment. The assessment concluded the likelihood of harm was low and this was listed as a moderate risk on the trust risk register. From January to March 2022, trust data showed an average of 350 patients per week met the trust's criteria for a VTE assessment in ED. During most weeks, only one patient had received a VTE assessment and some weeks, no patients received one. VTE assessments were the responsibility of the speciality teams who had accepted the patient. There was an action plan to improve this. Actions included adding the VTE assessment to the Inter-Speciality Professional Standards document and setting up a medical in reach team plus adding VTE assessments to electronic prescribing. These actions were not in place at the time of our inspection.

Other assessments undertaken included falls assessments, pressure risk assessments and care rounding, which recorded care interventions, for example the times patients were offered food, or repositioned. We did not find any omissions in these assessments during our inspection. Matrons told us they audited patient assessments and documentation and that no areas of concern had been identified as a result of these audits.

Emergency nurse practitioners were responsible for the care of patients in the injuries area which was open from 7.30am to 2am. There was a doctor present in MIU from 8am to 5pm and occasionally from 6pm to 10pm. When the ED was short staffed, ENP's were moved from the injuries area to cover the main department. This meant on some days the skill level in injuries area was not optimised. The injuries area was located away from the main ED leading to potential delays in accessing immediate senior support for deteriorating patients.

Some patients were streamed to an on-site urgent treatment centre (UTC) operated by another healthcare provider, which did not form part of this inspection. Patients were also directed to the UTC following full triage, or alternatively, the UTC accessed the ED waiting list, and actively chose patients to treat. There was a standard operating procedure (SOP) for this service which listed inclusion and exclusion criteria. Trust and UTC staff audited patients which were sent back to the ED following a referral to the UTC. Audit results showed an average of 5% of patients returned to the ED each week for a variety of reasons, including deteriorating conditions, alternative diagnosis, further tests or inappropriate referrals. Each case was examined for learning, and if required, extra training for referring clinicians was organised. The current UTC arrangement was temporary and trust leaders told us it was due to be relocated and redesigned by late Spring 2022, although longer term funding had not been agreed.

In the children's ED, not all nurses undertaking triage had received specific children's triage training, but the trust's triage training module was a combined programme covering both adult and children's triage skills. Adult nurses working in the children's department had completed paediatric competency training. There was a clinical sign off after nurses had been supervised in assessing both adults and children.

Urgent and emergency services

A patient management screen displayed an overview of patients in the ED. It showed the length of time each patient had been in the department, or on an ambulance, or were waiting for triage, or treatment. Managers saw where the greatest risks were and moved staff and resources around accordingly. Senior trust staff outside of the ED had access to the screen and viewed live information. A bed flow manager was based in the department every day and liaised with site managers, matrons and doctors to access beds for patients as soon as possible.

Risks were discussed at regular bed meetings every day. This included capacity in the department and the hospital, and staffing across all services. Staff were moved around the hospital to reduce risks in each area. Concerns and risks were shared and discussed at daily ED huddles and there was good oversight of daily issues by the senior ED team.

The service had 24-hour access to mental health liaison and specialist mental health support. Mental health support was available 24 hours a day. ED staff were aware of caring for patients with specific mental health needs, including carrying out risk assessments, and had received training on how to do so. ED staff referred patients to appropriate support services in batches of four or five, rather than individually on arrival and there were delays from 90 minutes to two hours during our inspection. The local commissioning groups had not set targets for wait times.

Staff shared key information to keep patients safe when care was handed over to other departments. However, for some patients who were in the department for more than 24 hours, this meant repeated handovers between several different ED teams. Some patients were handed over three times to both nursing and medical staff. There was a risk key information about a patient's care and treatment may get missed or delayed.

Nurse staffing

There were nurse vacancies in the emergency department (ED) and on some days, not all services operated fully due to staffing shortages. During our inspection the risks associated with gaps in the rota had some mitigation. The ED did not always have enough nursing staff with the right qualifications, skills, training and experience which increased the risk of patients suffering avoidable harm.

Managers regularly reviewed staffing levels and skill mix and moved staff to keep patients safe**.** Nurse staffing in the ED had been established as 34 nurses per day however, we were told the department had contingencies to function safely with 28 nurses. This included reducing the number of nurses taking triage, and the number of nurses working in the children's department. Children's nurses told us the department often closed beds, or areas, in the children's short stay unit due to inadequate staffing to keep patients safe. The children's department staffing establishment was nine per day shift, four of whom were required to be paediatric trained. Nurses told us this was not always achievable and there were occasions when only one paediatric nurse was on duty. During our inspection, there were two advance care practitioners and one emergency nurse practitioner, who were all registered children's nurses working in the paediatric emergency department. The 'Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings' document titled, "Standards for Children and Young People in Emergency Care Settings" (2012) recommends that EDs should have a minimum of two paediatric trained nurses per shift. Nurses working in the paediatric ED had completed children's nursing competencies including recognition of the sick or injured child, paediatric life support skills, and the ability to initiate appropriate treatment.

The ED rota from 14 March to 10 April 2022 showed nurse staffing gaps on most days. For example, on 14 March 2022, there should have been 34 adult nurses on the late shift, plus four twilight shift nurses. However, only 25 nurses were on the late shift and there were no twilight nurses. This meant at peak time in the early evening, the department was 13 nurses short. However, on some days, more staff had been on duty than planned. Senior nurses told us this enabled the department to flex staff across the whole of the service and place nurses wherever they were most needed.

The nurse vacancy rate was 20% for adult nurses and 25% for paediatric nurses. New nurses attended a trust induction and a local induction and were given competency booklets along with a full programme of mandatory training. Bank and agency staff were used and nurses from other wards or departments were moved to the ED if necessary, to keep patients safe. Agency staff used were regular staff who knew the department and were experienced ED nurses. New bank and agency staff underwent a local induction in the department.

Incidents relating to nurse staffing shortages had been reported across all areas of the ED. This included the paediatric ED, majors, and the ambulatory and ambulance assessment areas. The incidents demonstrated the extra delays patients experienced while waiting to access the service. There had been no serious harms reported as a direct result of staff shortages.

Nurse staffing was on the service risk register. Senior nurses continually recruited nurses and had recently appointed a group from oversees who were awaiting their conversion training. There were some mitigation to cover staffing shortages which included daily ED safety huddles and twice daily nurse staffing meetings across the trust. Nurses were moved across the emergency floor to where the risk was greatest. Other actions included opening and closing areas as necessary, including the GP assessment unit and asking matrons and senior nurses to cover clinical shifts.

Medical staffing

There were not enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care at all times. More consultants were required to run the department safely when it was overcrowded. Patients waited a long time to see a senior decision maker.

Consultants were in the ED 8am to 1am every day which met the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours consultant presence every day. Consultants stayed longer in the department at night if required. An on-call consultant covered the out of hours period seven days a week.

During our inspection, consultants told us there were not enough of them to cover the whole of the department safely, all of the time. This had been mitigated to some extent by increasing the number of registrar grades working each day. Nevertheless, consultants said they felt under enormous pressure in the department due to the demands of the service.

There were 30 whole time equivalent (WTE) consultants working in the ED against a target of 31 WTE. Consultants told us they believed more than 45 consultants were required for this department due to the number of patients using the service. We did not see any evidence of direct harm to patients due to consultant shortages, however, many adults and children waited a long time to be seen, treated and admitted or discharged. Consultant meeting minutes recorded that even having a full complement of staff, the daily staffing did not allow for safe effective care for all patients.

Eight paediatric consultants worked in the paediatric ED. Consultants from the adult department provided cross cover for paediatric ED when required. Paediatric consultants worked from 8am to 1am and registrars with specialist training in paediatric medicine covered out of hours. Senior paediatric support was available from the children's ward if required in an emergency.

Junior doctors told us they felt supported while working in the department and had been exposed to some good learning opportunities. Trust leaders told us the junior doctor survey gave largely positive feedback. Registrar staff said they often worked outside of their specialist area to meet the demands of the service.

Medicines

Urgent and emergency services

Staff did not always follow systems and processes when safely prescribing and administering medicines. However, medicines were stored securely.

The process for enabling patients' timely access to their regular time critical medicines whilst they were held in the ambulance awaiting access to the department was not always safe. When patients were identified as having a time critical medicine, they were prioritised for admission. If a space was not available in the ED there was no process to enable patients to have access to these medicines whilst they remained on the ambulance. Once patients were in the department, they had timely access to their medicines.

The trust used a paper-based prescribing and medicines administration system in the department. We looked at seven prescription records and saw that drug histories and allergies were recorded to allow for safe prescribing of medicines. Initial venous thromboembolism (VTE) risk assessments had not been completed for any of these patients, despite patients being in the department for between 18 and 23 hours.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

A clinical pharmacist was based in the department Monday to Thursday as part of the frailty team. They reviewed patient's medicines, spoke to patients about their medicines and liaised with care homes if required. No pharmacist support was available to the wider department to provide regular clinical support to staff, but staff did know how to contact a pharmacist when they needed them.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines, including controlled drugs and IV fluids, were stored securely. Prescription pads were stored securely and there was an audit trail to monitor use of these forms. Prescription charts where kept outside the individual patient bays, in an area accessed only by hospital staff.

Staff followed current national practice to check patients had the correct medicines. Patients drug allergies and regular medicines were recorded by the assessing doctor. Staff had access to summary care records to support this process.

Is the service responsive?

Requires Improvement 

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

Access and flow

People could not always access the service when they needed it and did not always receive care promptly. Specialists did not always review their patients in ED within agreed timescales which increased blockages in the department and delays to treatment. Poor hospital flow led to delays in accessing hospital beds for patients who required an admission.

Waiting times and treatment times were monitored and compared to national standards. There were systems to manage the flow of patients through the emergency department (ED) and to discharge or to admit patients to the hospital. Senior managers could view the length of time each patient had been in the department, and what they were

waiting for, including speciality reviews or bed admissions. The system displayed the number of patients arriving at ED from ambulances and by walk ins. The data was discussed at bed meetings during the day. However, due to the number of people using the service, and capacity issues within the rest of the hospital, there were long delays in accessing assessment, treatment and admission or discharge, and national targets for ED care were not met.

The inability to review and admit patients in a timely way increased overcrowding and reduced flow in the department. The Department of Health and Social Care standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. This is known as the Emergency Access Standard (EAS). The England average EAS is 75%. The trust's February 2022 board papers reported the EAS for December2021 as 69%. During our inspection, on 10 April 2022 the EAS was 46% and on 11 April 2022 it was 55%. On 1 April 2022, the average waiting time for a decision to admit, discharge or transfer was over five and a half hours. From 21 March to 18 April 2022 the trust failed to achieve an EAS greater than 61% on any day.

Some patients waited more than 12 hours before a decision about their care was made and waited even longer for a hospital bed to become available. In December 2021 the trust reported 582 breaches for 12 hour trolley waits. During our inspection on 12 April 2022, 42 patients waited more than 12 hours and from 21 March to 18 April 2022, 853 patients waited more than 12 hours. On 11 April at 9pm, the longest wait in ED for a hospital bed was 24 hours and 46 minutes.

There were delays in specialists reviewing their patients in ED. The Inter-Speciality Professional Standards document required specialities to review their patients in ED within 30 minutes of receiving the referral. This standard was not upheld by clinical leaders across specialties which directly impacted on patient care in the department. ED staff had done a one off audit which demonstrated a clear deviation from the 30-minute rule. Senior managers across the trust were aware of this and repeatedly failed to enforce the standard, which had been raised as an issue since 2010. This was highlighted as a concern during our last inspection in December 2019, and except for some surgical specialities where improvements had been made, it still remained a serious concern.

Some speciality teams were based offsite and carried out virtual reviews. Medical patient reviews were not undertaken out of hours and patients arriving in ED after 10pm waited until the following day for a medical opinion. There was no in reach medical services in the department, although leaders told us they were making plans to introduce it. We were not told of a date when this service would be implemented.

The lack of medical doctors in ED led to many patients waiting in the ED longer than necessary resulting in delays in decisions about their care, and delays in commencing specialist treatment. Senior ED doctors were concerned that some patients deteriorated without early intervention from specialists and said that some patients were admitted to a hospital bed unnecessarily due to a lack of face to face specialist reviews in ED.

There were insufficient beds available in the rest of the hospital to accommodate all the patients in ED who needed admitting. Throughout most of our inspection, there were more than 50 patients waiting for a bed in the trust. ED doctors were frustrated by a lack of progress in addressing the trust flow issues and poor hospital flow was identified as having a major impact on the care of their patients.

Surgical in reach was available 9am to 5pm along with the same day emergency care (SDEC).

ED escalation levels were determined by the regional health economy Operational Pressures Escalation Levels (OPEL) management system. OPEL levels were graded one to four. OPEL one was normal working, and four was the department was under severe pressure, and unable to sustain business as usual. The ED had been operating at OPEL four for several weeks prior to our inspection. The trust had activated their 'Capacity and Flow Escalation Policy and Whole Hospital

Urgent and emergency services

Response to Emergency Care Demand' which included steps to be taken during OPEL four. During our inspection the trust told us it was carrying out the actions listed in the policy including identifying patients suitable for discharge as soon as possible and allowing discharges up to 11pm at night. When necessary, patients who were waiting on a ward for an admission to a hospital bed were bedded in areas and on beds which were not properly configured. The trust did have a standard operating procedure which staff followed when this was required. The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status.

In January 2022, 9% of patients left the department without being seen. This had increased from the previous year when 2% of patients left without being seen. Nearly 8% of patients who attended the ED in January 2022 reattended within seven days, compared with less than 1% in January 2021.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs. When the department was working above capacity, not all individual needs could be accommodated all of the time.

Staff were discreet and responsive when caring for patients admitted to the unit. Staff interacted with patients in a respectful and friendly way. However, due to the volume of patients using the service, and overcrowding in some areas, some patients had their conversations overheard by others and it was difficult to share confidential information privately.

Some areas of the ED provided mixed sex accommodation overnight. This was permitted and within national guidance on mixed sex rules in emergency care but it was difficult for staff to always respect the individual personal, cultural, social and religious needs of each patient cared for in these areas.

When the department was full, some patients individual care needs were not met. For example, patients who had been in the department for many hours told us they had not been offered assistance or facilities to wash. However, as the department was established for emergency care, and not intended for long stay patients, it was not staffed or built to facilitate one to one personal care for lots of patients. Senior nurses had recognised this and had recruited more healthcare assistants to help provide hands on nursing care, which was more akin to traditional inpatient ward-based care. They had also facilitated increased access to one to one care for individual patients when this was required. Nursing care rounds had been completed on most patients in a timely way.

Most patients were aware what they were waiting for in ED. Some patients admitted to the ED were unaware of the next stage of their ED journey and this was particularly noticeable in patients who were told they were waiting for a bed to become available in the hospital, but they had no idea where or when this would be.

Is the service well-led?

Inspected but not rated

Leadership

Local leaders and managers had the right skills and abilities to run the service and were visible to staff in the emergency department (ED). They supported staff to develop their skills and take on more senior roles.

Urgent and emergency services

The senior leadership team for emergency care was led by a head of nursing, an operations director and a clinical director who were all experienced leaders with strong decision making abilities and had the appropriate levels of operational knowledge to lead the department in pressurised circumstances. Both directors were responsible for care across the emergency department service and the medicine service. There was an emergency care consultant who was responsible for clinical care in the department, and who worked alongside the head of nursing to provide local leadership direct to the ED team.

The clinical leadership team were very visible in the department. Staff knew who they were and how to contact them if they needed support. Leadership was clear, positive and collaborative. It was clear from all staff we spoke with that leaders were supportive of their staff and passionate about their service. They were aware of how the ED environment and pressures in the workplace affected the welfare of their staff. They worked hard to ease the pressures of working in such a busy environment.

A senior nurse oversaw care in each clinical area. It was not always possible for us to identify who that person was, however, junior staff told us they knew who to ask if they had queries or concerns about patients.

The nurse in charge of the shift had responsibility for overseeing the smooth running of the whole department, including monitoring waiting times and moving staff around the department to cope with demand and capacity. They escalated patient concerns to medical staff or senior managers when and if appropriate.

Senior staff in the department were fully aware of the challenges they faced and felt the full responsibility of delivering a safe service for all. The medical team and the nursing team worked well together and spoke highly of each other's abilities and support.

ED consultants were represented up to executive level by a medical consultant who was not trained in emergency medicine and who also represented the medicine team. This was raised by staff as a concern as it meant the ED leadership team did not have direct and independent access to the board. It also represented a potential conflict of interest between medical doctors and emergency care doctors. There was additional concern that decisions may be made at board meetings about the department without independent ED presentation being present. This was raised during our previous inspection in December 2019. Consultants told us they were able to approach any of the senior leadership team freely and discuss any concerns they had, however, formal representation and feedback to the senior leadership team was via a doctor from the medical speciality.

Since our last inspection, the trust had established an urgent and emergency care strategic board (UEC board) which included ED physicians along with other healthcare providers including GP's, ambulance services and clinical commissioning teams and which fed into the trust board.

Staff development was encouraged at all levels and senior staff told us they were proud of the department's ability to 'grow their own' senior staff. Nurses told us they were encouraged to apply for more senior roles within the department and registrars were supported to apply for consultant grade status. This enabled staff to develop their clinical and leadership skills in an area where they already had a good working knowledge and the support of good teamworking.

Management of risk, issues and performance

Urgent and emergency services

The service had systems to monitor performance. Relevant risks were identified and escalated, and some actions were taken to reduce their impact, other actions were not effectively implemented or monitored. Performance in the emergency department (ED) was not in line with the national average, and patients waited a long time to be seen, treated, and admitted or discharged. A lack of patient flow in the hospital hindered the department's ability to make progress.

The department risk register listed several high-level risks, most of which were lowered to some degree by mitigating actions. For example, children's triage times had a risk score of 16 (high risk), which was reduced to 12 (medium risk) by the introduction of visual assessment clinicians (VAC nurses), which prioritised those waiting for triage.

Medical and nursing workforce capacity in the major's area was risk rated 20 (high risk) in November 2020 and remained so even after controls were put in place. It was due for review in April 2022. The risk record stated that the department sometimes functioned at 200% capacity. One of the control measures in place was the maintenance of the Inter-Speciality Professional standards which required admitting specialities to review their patients with 30 minutes. Staff of all grades told us that this standard was continually not met and posed a risk to patients using the service.

ED consultants audited speciality response times and shared the findings with senior trust leaders. The audit demonstrated long delays and showed that the Inter-Speciality Professional standards were not being adhered to. Senior leaders told us they were making plans to address this and to remove unnecessary delays. However, delays in speciality reviews had been a concern in the department since 2010 and ED staff told us very little had been done to improve the situation. Delays were seen particularly for medical patients requiring cardiology and respiratory reviews, along with oncology patient reviews. Trust plans to address the issue included an in-reach medical team based in the ED 24 hours a day, seven days per week and having cardiology and respiratory physicians based in ED, although there was not date when this was expected to start.

Some specialities had improved their response times since our last inspection, and staff in ED highlighted that most of the surgical division were now very supportive.

Risks remained for patients who were waiting a long time in the ED. The senior leadership team had committed to look for harms as a result of patients waiting in the department for 'a long time' and had instigated some plans to reduce the risks for these patients. However, for some areas of concern, the risks remained unmitigated. For example, not all patients who required a VTE assessment had received one, and not all patients suspected of sepsis were treated within the appropriate timescales.

It was difficult to establish who had clinical ownership of patients who were waiting in ED for a hospital admission. While the trust medical director's position was patients in ED who had been accepted by speciality teams, were the responsibility of the speciality team, clinical directors had failed to enforce it. This was evidenced in minutes from a meeting between the trust medical director and ED consultants in April 2022.

It was not possible to mitigate all the risks associated with running a department at 200% capacity, and when there were more than 200 patients in the department it was difficult to have thorough oversight of every patient. Opportunities existed for patients to deteriorate rapidly without being detected. For example, in majors, not all patients had their early warning scores reassessed in line with guidelines, and some walk-in patients were in the department for more than an hour before a set of observations were recorded.

Urgent and emergency services

Hospital flow was recognised by the senior leadership team as a serious risk to the department's ability to provide safe care and treatment and achieve the performance standards required by both the royal colleges and NHS England. There was an action plan which focussed on improving this. The plan was updated regularly, and the key interventions were priorities by the trust.

The action plan had been developed with colleagues across the trust and the urgent and emergency care pathway and was aligned with the system urgent and emergency care (UEC) plan. The action plan was monitored through the trust UEC steering group who reported to the Executive Finance and Quality Board, and the Operational Performance Committee.

The largest group of actions were designed to either manage the flow in, manage the flow through, or manage the flow out. It included:

- Increasing the urgent treatment centre capacity;
- Working with primary care to prevent unnecessary ED attendances;
- Reviewing trust discharge process;
- Increasing medical in reach into ED;
- Having some cardiology and respiratory doctors based in the ED;
- Changing patient pathways;
- Virtual ward expansion; and
- Completing capacity reviews with the system.

Flow in, and flow through actions were dated Spring and Summer 2022. Most flow out actions were later in the year. Other key actions included improving live data visibility, with regular reporting on speciality review times and more medical input direct in ED.

One of the actions, to be completed by June 2022, was to set up speciality level review meetings to define response times and the actions speciality teams needed to undertake to ensure swift response to ED. The actions required were to be defined by the individual speciality. However, an acceptable response time already existed, in the form of the Inter-Speciality Professional standards document, which considered 30 minutes to be acceptable. It was therefore difficult to see what impact this action would have.

Some actions to ease pressure in the ED had centred around increasing ED capacity, for example by moving the injuries area away from the main ED. However, this had not improved patient flow in the department, as the main disruptor to the service was the lack of flow out of the department.

Some patients from the ED required an admission to hospital to receive a specialist review. However, if specialist reviews had been done in the ED, some patients may not require an overnight admission to a hospital bed and could be discharged straight from ED. This would potentially have a positive impact on flow. NHSEI were supporting the trust with patient discharges to improve flow.

ED mortality and morbidity meetings took place to discuss any deaths which had occurred unexpectedly in the ED and were used to identify learning and reduce risks to patients. The reports from March to April 2022 showed several cases had been discussed which highlighted the 'busyness' of the department, the 'lack of available cubicles for sick patients' and, 'seeing so many patients in one day'.

The risks of running the department without sufficient staffing were recognised, and recruitment attempts were ongoing, particularly to nursing roles. Further risks of running the department without always having the necessary skills were also recognised. For example, the lack of senior medical staff meant there were no regular reviews for patients delayed on the back of ambulances, which had led to potential missed diagnosis, and the lack of available experienced nursing staff to triage and carry out the VAC role meant some minor injuries clinics ran without sufficient seniority.

Senior clinical staff told us about the pressure they felt working in the department faced with the everyday overcrowding and capacity risks. The trust were aware of this pressure, and had tried to assure staff these risks belonged to the trust and the system and not to individual ED staff. Trust board papers from February 2022 report that the ED Friends and Family Test indicated higher levels of dissatisfaction around waiting times and delays and recorded that work was being undertaken to improve the communication with patients who were waiting.

Culture

Staff and managers working in the emergency department (ED) promoted a positive culture that supported and valued one and other. Staff were respectful of each other and demonstrated an understanding the pressures they each faced.

Nurses and doctors in the ED spoke very highly of each other and worked well as a team. There was a good understanding between staff in different roles and the pressures they each faced. All staff spoke highly of the local team. ED nurses and doctors worked well together.

Nursing staff said they knew who to approach if they had concerns and some told us they had raised issues with line managers or matrons in the past and that they had been supported and encouraged in this process. Staff told us they felt comfortable in reporting incidents, although some said they did not always receive feedback.

Clinical leaders were highly visible in the department and it was clear they were respected by their teams. Matrons and other senior staff worked clinical shifts in the department regularly to cover staff shortages and help teams deal with the workload. There were team meetings and daily huddles where staff could raise issues.

Junior doctors spoke highly of their training experiences in the department and said their consultants were very approachable.

There was a disconnect between the culture of supportiveness within the ED, and that felt by staff working in ED from other areas of the hospital. Staff said many of the problems within the ED were the result of other services within the trust not taking responsibility for their patients, yet it was perceived that the onus was on ED staff to solve the issues.

The trust senior leadership team (SLT) told us about their regular department walkabouts and drop-in sessions, plus their open-door policy. ED consultants and senior nurses confirmed they had access to trust leaders. However, some

staff said they had not seen the SLT in the department, and that they were not aware of the walkabouts. Some staff told us about personal welfare issues which they believed were the result of the ED workload and daily pressure in the department. They believed not enough was being done to address these issues and were concerned about 'good' staff leaving the service due to unsustainable levels of pressure.

Areas for improvement

Action the trust MUST take to improve:

- The trust must ensure that patients arriving by ambulance are handed over to trust staff in a timely way. They must reduce the length of time and the number of, patients who are cared for in the back of an ambulance Regulation 12 (2) (a) (b) (i)
- The trust must ensure that all patients are triaged and assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.
- Safety measures to protect patients must be implemented to ensure all environments are safe for all patients using them. Regulation 12 (2) (a) (b) (i)
- The trust must ensure that patients receive medical and speciality reviews in a timely manner. Regulation 12 (2) (a) (b) (i)
- The trust must ensure all patients delayed on the back of an ambulance have an assessment carried out by an appropriately skilled and experienced decision maker. Regulation12 (2) (a) (b) (i)
- The trust must ensure that the ED environment is established in a way which always protects the dignity of all patients using the service. Regulation 12 (a)
- The trust must ensure that there are enough consultants working in the department to keep patient safe when even in times of overcrowding. Regulation 18 (1)
- The trust must ensure that there are always enough nurses working in the department every day in order to keep patients safe. Regulation 18 (1)

Action the trust SHOULD take to improve:

- The trust should ensure that governance processes are sufficiently robust. Actions from action plans and other improvement initiatives should be verified to ensure they have been effectively implemented and where appropriate, change audits undertaken to demonstrate sufficient improvements have been made.
- The trust should consider improving emergency department consultant representation at executive level.
- The trust should ensure all staff wear and change their personal protective equipment in line with local and national guidance.
- The trust should ensure all patients waiting on the back of an ambulance receive their critical medicines in a timely way.

Medical care (including older people's care)

Requires Improvement 

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

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service mostly managed safety incidents well and learned lessons from them.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always have enough staff to care for patients and keep them safe. Falls related incidents remain a concern with over 60% of reported serious incidents, relating to falls.
- Key services were not always available seven days a week.
- In-reach services to ED were not always available.
- Staff told us that the reduced staffing levels impacted on their wellbeing at times.

Is the service safe?

Requires Improvement 

Mandatory training

The service provided mandatory training in key skills, which included the highest level of life support training, to all staff and made sure everyone completed it.

Systems were in place to monitor staff training and highlight areas for improvement. We saw that the electronic system recorded mandatory training for each member of staff and could be used to identify any noncompliance. On all wards we visited, staff had a 100% completion rate for mandatory training, which was clearly linked to staff appraisals.

Staff told us that they had completed the mandatory training but found it difficult to access some of the supplementary training, to develop in their roles.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

The service performed well for cleanliness. Ward areas and equipment were clean and well-maintained. Staff completed safe cleaning processes on all wards visited. This was in accordance to the trust policy for Infection Prevention and Control (IPC).

Signs describing the procedures for good hand hygiene and use of protective equipment, were located appropriately in all areas.

Staff used the relevant protective equipment and followed hand hygiene processes, when caring for patients. There was good access to face masks, hand gel and equipment cleaning materials.

Patients that had been identified as having an infection, such as COVID 19, were isolated to prevent further spread of infections. Patients and the areas they were admitted to, were managed safely.

We saw doctors cleaning stethoscopes with sterile wipes between uses.

Environment and equipment

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

Staff completed daily safety checks of specialist equipment such as resuscitation trolleys, hoists, and beds. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure. We found all checks were completed daily with the name of the staff member, date, and their signature.

Patients could reach call bells to alert staff if they required assistance. We saw that staff reacted to the call for assistance in a timely manner. However, one patient told us that at night the staff did not always respond quickly. We observed that some patients did not use the call bells and routinely shouted the staff for assistance. All patients we spoke with told us that they knew how to use the call bell system and that they were available to use.

Due to the impact of COVID 19 pandemic, some wards had stopped using communal areas, such as day rooms, to reduce the risk of infection. Wards had not reintroduced access these areas to patients. On the wards we visited these areas were maintained well and remained part of the cleaning schedule. Some rooms had been re-purposed to suit the needs of the ward.

All areas within wards were part of a daily cleaning schedule which was checked and signed for by staff to ensure a good level of cleanliness. Areas could be cleaned on request outside of the cleaning schedule.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Staff gained access to wards and clinical areas with electronic cards or a security code, to ensure controlled access to wards.

Visitors accessed the ward using a call bell, which enabled staff to monitor visitors and patients entering the wards. We saw examples where staff challenged visitors to ensure only appropriate access was gained, when visitors had followed staff into wards.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, falls related incidents remain high.

Staff completed risk assessments, in line with policy, for each patient on admission or arrival, using a recognised tool, and reviewed this regularly. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used to identify patients at risk of deterioration.

All areas had a screen to display information electronically, a dashboard for review of relevant risk assessments, such as NEWS2, with colour coding to aid in recognising patients at risk. The use of an electronic system meant senior nursing staff and medical staff had an oversight of the clinical risk of unwell patients. Patients identified as deteriorating were escalated to senior clinicians for re-assessment. Review by a specialist consultant could be facilitated to ensure appropriate care was given to the patient. However, cardiac, and respiratory patients could experience delays in respect of face to face specialist consultant input.

An electronic system was used to help manage patient risk and provide clear and up to date information to staff. The system provides flags linked to risk, along with information on referrals. Multi-disciplinary teams had access to the system and information was clearly available to show which staff were caring for the patient, levels of risk and referrals to specialist services.

We saw the use of Glasgow admission prediction score (GAPS) to aid in identifying patients for ambulatory care pathways. This supported the admission process and did not rely on clinical decisions alone.

Wards had daily safety huddles to discuss risks and care plans for the individual patients on wards. A record was kept ensuring all staff had access to the information discussed in safety huddles. Safety huddles were done several times a day to discuss changes in risk or to keep staff informed of relevant information.

We observed safety huddles and reviewed notes taken on wards. A multi-disciplinary approach was taken, and staff discussed, patient care, risks of falls, pressure area care, sepsis, and other patient related care plans. Equipment issues and staffing levels were also discussed and escalated appropriately.

Although assessments were managed well using the electronic system, of three assessments we looked at, we found that a venous thromboembolism (VTE) assessment had not been re-assessed in the appropriate time frame.

There had been an improvement in the recording and management of falls since July 2021. Assessment and management of the risk of falls was completed by staff, with the support falls lead nurses, and flagged appropriately. We saw six patient falls assessments completed correctly and appropriate follow up assessments. These were available electronically and in paper notes. However, falls related incidents remained a concern with over 60% of reported serious incidents relating to falls.

National audits for falls indicate that the trust meet all the required standards and practices for falls management.

Medical care (including older people's care)

Staffing

The service did not always have enough staff across the medical care services which had been identified as a risk, by the trust. Most areas did not have enough staff to meet the planned commitment and that sickness levels had impacted on the availability of staff to be redeployed. However, there were systems that allowed twice daily reviews of staffing levels and senior managers were able to prioritise where staff were needed.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training, and experience to meet planned levels. However, managers regularly reviewed staffing levels and skill mix, and escalated concerns appropriately.

There was a vacancy rate of 25% and a 10.4% sickness rate across the nursing staff in medical specialties at the time of our inspection. This caused some wards to be short staffed. These issues were escalated, and nurses were often re-deployed to other areas during their shift.

Managers calculated and reviewed the number of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance, but this was not always achievable due to vacancies and sickness.

Bank and agency staff were used to fill gaps in rotas. These staff had an induction and were trained appropriately. Some substantive trust staff decided to work as bank nurses during the COVID pandemic. However, many of the bank and agency staff return to the same wards regularly to ensure consistency.

The recruitment of overseas nurses has resumed, following a pause due to the COVID pandemic, to help address the issues with staff shortages. The trust has also recruited nurse associates to support nurses and have implemented pathways for them to progress to registered nurse training. There had been an increase of 3% in staff employed by the trust in medical care services in 2021.

On the day of our inspection, the actual nurse staffing did not meet planned nurse staffing levels on five wards visited. These issues were escalated at twice daily meetings and with the manager on call.

Staff were shared within and across each of the three main hospital sites, within the trust, to manage staffing levels and prioritise care for patients. We saw an example where a nurse had been moved from ward 33 to AMU to cover.

The trust used a safe care electronic tool to monitor staffing levels and ensure staff were utilised across the service. This could be accessed by all on call managers and by ward staff to see the staffing in their area.

We saw matrons working with senior sisters to coordinate staffing levels to help support areas with lower staffing and higher patient acuity. On occasions matrons became part of the nursing team to support with patient care. Discharge co-ordinators, when available, and housekeepers (who cover nutrition and hydration), were also used to help free up nurses from some tasks.

Medical staffing

Medical care (including older people's care)

The service did not always have enough medical staff with the right qualifications, skills, training, and experience to meet planned levels. Managers regularly reviewed staffing levels and skill mix and gave new and locum staff a full induction.

Up to December 2021 there had been a 4% increase in medical staffing in the trust, compared with the previous 12 months, which equated to a 1% increase across medical care services.

We saw data that indicated a rise in sickness rates from 1.9% in November 2021 to a 3.6% in January 2022. The fluctuation in rates compares to the increase and decrease of COVID 19 infection rates and is within a similar range of national variations.

We found medical staffing was an improving picture within some areas, such as stroke, actively recruiting to registrar posts. Some doctors were moved from one area to another during their shifts, to cover priority areas. We saw an example of doctors being deployed in other areas and then returned to the ward for the rest of the day. However, a junior doctor being moved from the stroke ward to cover in the AMU, had caused a shortfall of medic cover on the ward.

Recruitment of consultants that have an interest across general medicine had increased. This was an initiative to provide a wider range of care across medical wards to support the needs of patients.

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.

We reviewed 18 sets of notes, which included written records and electronic records. In most cases, there were written risk assessments along with an electronic copy. In 16 out of 18 records we found they had been completed appropriately, with information available to staff. Electronic records were clear and easy to use. Assessments and flags were in place to warn staff of any patient needs, such as risk of falls. In all but one, paper assessments were completed appropriately and linked to the electronic notes systems.

Medicines

Staff followed systems and processes to safely prescribe and administer medicines. The service had systems and processes to safely prescribe, record and store medicines securely. However, in two cases we observed medicines had been given to patients later than prescribed.

Staff stored and managed all medicines and prescribing documents in line with the trust policy. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff received information about safety alerts and learning from medicines incidents through regular 'Insight' bulletins on the intranet. Medicine incidents were reported and investigated appropriately.

Electronic devices used when prescribing and administering medicines were secured when not used by staff. On the GP assessment unit, prescription pads were stored securely and there was an audit trail to monitor use of them.

Medical care (including older people's care)

An electronic system allowed pharmacy staff to prioritise new patients and complete medicines reconciliation (the process of accurately listing a patient's medicines they were taking at home and comparing it to what is prescribed whilst they are in hospital) in a timely manner. Staff had access to summary care records to support this process.

Patients on an older people's ward did not always receive their medicines on time due to staff shortages on the ward. We saw two patients received their morning medicines, which included medicines for pain relief, over three hours late. This caused subsequent doses to be delayed, with patients receiving them late in the evening.

Staff reviewed patient's medicines regularly but did not always provide specific advice to patients and carers about their medicines. A patient told us they had been prescribed a new medicine but was not sure what it was for.

We saw evidence of effective communication of medicines issues between pharmacists and other healthcare professionals. Medicines were reviewed regularly on ward rounds on the older people's wards and general medical wards. A clinical pharmacist visited the medical care wards, Monday to Friday, reviewed patient's medicines and would speak to patients about their medicines if required.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We saw that wards had achieved appraisal rates of 90% or over. On three wards we visited there was a 100% of nurses had completed appraisals. Staff told us that senior nurses had discussed progression opportunities and supported nurses in changing roles to gain experience in other areas. Supervision records formed part of the appraisals for staff. The appraisal rate was 100% on the wards we visited.

Link nurses were available on wards to support specific care needs of patients. For example, wards we visited had falls link nurses, that had been trained in assessing and managing patient falls.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals on the medical care wards, worked together as a team to benefit patients. They supported each other to provide good care. However, this was not always achieved within the emergency department.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Senior staff held risk management meetings four times daily to discuss key issues relating to patient care, staffing and patient flow. These included non-clinical staff, senior clinical managers and on call managers. During inspection we attended a meeting and observed issues that had been escalated. We saw examples where staff had been moved from one ward to assist a patient that required one to one support.

Medical care (including older people's care)

Clinical staff reviewed each patient on a ward, called a board round. These reviews involved medical staff, nursing staff and allied health professionals to ensure a multidisciplinary approach to patient care, was achieved. Often discharge coordinators were involved in these reviews to support appropriate discharge of patients.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Reduced access to discharge coordinators at weekends and at other times, contributed to issues with patient flow. However, following COVID restrictions being lifted, care agencies have been permitted to reintroduce dedicated staff to support with discharges and support with discharge processes.

Some services were not available at weekends and this caused some delays for patients. For example, there were no occupational therapist services available to support discharges at the weekends. We were told that a patient on ward 29 was delayed due to the ward not being able to fulfil agreed care plans and potentially could have been discharged earlier.

In some cases, we were told access to imaging services could be delayed for patients that moved from the emergency department into medical care areas. Access to these services were sometimes difficult after 5pm and at weekends. We were told that in most cases staffing levels were the factor that caused delays.

Is the service caring?

Inspected but not rated

Compassionate care

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

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

Patients said staff treated them well and were very caring. However, we were told that staff were often “very busy” and this could cause frustration to some patients when requiring support at peak times.

We observed staff interact with patients living with dementia in a calm and caring manner. On several occasions we saw staff helping patients make telephone calls to loved ones.

Understanding and involvement of patients and those close to them

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

Medical care (including older people's care)

Staff made sure patients and those close to them understood their care and treatment. We saw in patient records that staff had spoken with patients' families to provide information relating to their care. We saw staff talking with family members to inform them of their loved one's wellbeing.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Specialist support staff would visit the older people's wards to help with improving communication and support for vulnerable patients.

All patients and visitors we spoke with felt confident to raise concerns with staff. There was information displayed on the wards that informed patients and visitors of the process for concerns to be discussed or escalated.

Patients gave positive feedback about the service. We saw patient feedback information displayed on wards, with cards from families, thanking staff.

Is the service responsive?

Requires Improvement 

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. Some specialty medical services could not always provide an in-reach service into ED. However, it worked with others in the wider system and local organisations to plan care.

We saw the introduction of care pathways for older patients. There was an in-reach pathway into ED that currently provided a service five days a week with consultant support in the morning and afternoon. This team were known as the "Frailty Emergency Squad" (FES) and they focused on admission avoidance by signposting or referring to more appropriate services instead of the acute hospital. In-reach services were not available for any speciality, after 8pm.

We saw a system wide approach to caring for older people. A process has been set up to include the local NHS ambulance provider to prevent admission to hospital when more appropriate care can be found in the health system. This was applicable to care homes and includes patients living at their own home.

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. Processes were in place within medical care services, to ensure cardiac and respiratory patients were directed to a different hospital within the same trust for more specific care, when needed.

The use of electronic patient record systems helped ensure that the most up to date information was available to those caring for patients. Staff could see referrals, make referrals, and follow the progress of patient care from specialist teams or other allied healthcare professionals. Assessments were updated and staff had access to the bed status for those being admitted to wards.

Medical care (including older people's care)

There was limited in-reach clinician availability to assess patients awaiting a medical bed. For example, patients waiting in the emergency department for a specialist medical bed were delayed in seeing a specialist clinician. In some specialties, such as stroke care, availability of a specialist clinician to provide in-reach into ED had improved due to recent employment.

We saw the use of daily clinics in the GP assessment unit area, known as “hot clinics”, to enable patients to be seen by specialist clinicians. Neurology clinicians were available three times a week and diabetes and nutritional nurses, were available Monday to Friday. However, there was no input from cardiology and respiratory clinicians as these were based at a different hospital site. However, access to specialist cardiology and respiratory care advice was regularly conducted by remote access and telephone, for those admitted through ED and awaiting assessment for a variety of conditions.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment were not always in line with national standards. Although there was a reduction in elective admissions during the COVID pandemic, the medical care services saw a 4% increase in emergency admissions and a 14% increase in day case admissions.

The flow of patients into the medical wards often came from a primary care referral and then into the emergency department (ED). Patients were then transferred through the admissions unit to a specialist medical ward. This resulted in long waits for patients within ED for patients waiting for appropriate admission to wards.

The discharge lounge was not used effectively and could not take patients, whose discharge arrangements were complex. These discharges could include patients living with dementia or those that were vulnerable due to learning difficulties.

Between 1st January 2022 and the Inspection on 14th April 2022 the highest overall number of medical optimised for discharge (MOFD) patients was 256 on 12th January 2022 and the lowest was 156 on 31st January 2022. Delays were seen due to a variety of issues. On inspection in medical care services, we saw some patients were awaiting coordination from social care agencies to provide appropriate care packages, allowing appropriate discharge. Patients with complex needs were often those that waited longest for an appropriate discharge. We were told that patients’ discharges could also be delayed whilst awaiting diagnostic or imaging procedures to be completed. Staffing issues also contributed to delays; for example, when the availability of discharge coordinators and nursing staff was reduced this would impact discharge processes.

Patients with complex needs could not be discharged from the discharge lounge and so this disrupted the admission process for other patients. On occasions the patient being admitted would require safer placement within the ward area to wait for a discharge to occur. These patients were reviewed to assess risks and aid in prioritising admission to wards.

We saw on one day that only six patients were in the discharge lounge waiting for discharge. This was a reduced number, compared to the full capacity of the discharge lounge and potentially impacted on those patients that might be requiring a safer placement.

Medical care (including older people's care)

When patients' discharges were delayed this impacted on medical specialities ability to free up capacity and flow through the ED and medical care wards. Managers and staff worked to make sure patients did not stay longer than they needed to. Clinicians worked together to review the electronic patient records and other electronic systems, to update risks and patient needs to improve progress of care and patient flow. Staff discussed patient discharge plans daily to support the process and to update availability of beds on wards.

Areas, such as the GP assessment unit used the electronic system to manage the process for admitting patients to wards. This meant patients waiting to be admitted, could be managed according to individual needs, as it was based on risk, priority, and urgency. This reduced the number of patients waiting in the emergency department areas. Although the aim was to not have patients staying overnight, the unit had appropriate facilities and staffing to manage patients overnight, if required. On the day of the inspection there were seven patients that had been waiting overnight for admission to a ward. A process was in place to assess patients that may need to stay overnight.

Processes had been introduced and were monitored by staff to improve patient care. For example, falls assessment processes included reviews when changes in patient presentation occurred, and post fall reviews to help reduce future risk. Specialist nurses supported the process to ensure consistency and that learning was shared. Falls safety letters were produced to increase staff awareness.

Is the service well-led?

Inspected but not rated

Leadership

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

The service had a clear management structure. We saw competent leaders that had the right level of experience to manage teams across the service. They were present to guide and support staff at difficult periods and demonstrated a range of skills to ensure care was provided appropriately. They supported staff to improve and encouraged them to take on more responsibility, where appropriate. There were no vacancies in senior posts, and we saw that some had been filled by staff that had been developed into the roles.

Medical divisions were divided into clinical management groups (CMG's) which incorporated some services on other hospital sites, within the trust. CMG's had lead consultants and senior nursing staff providing clinical leadership across the areas. Each CMG had a clinical director, assistant director, and a head of nursing. There were also heads of operations to support the CMG. Specialties within the CMG also had a head of service and a general manager to have oversight of each specialist service. Leaders told us that risk was discussed across different specialities to encourage joint solutions and support a learning environment.

Senior leaders were visible, and staff told us there were regular visits by the chief executive officer (CEO) to areas across the site. Other senior staff were available to support across the service and could be contacted for advice and support. Staff told us that other senior clinical leaders were available to support staff and areas across the sites. Matrons were visible and approachable across their areas, and an on-call system or bleep system was available for staff to escalate issues to.

A weekly message was sent out to all staff by the CEO to update on issues concerning the trust and invite questions from staff. Staff told us about one issue that was raised to the CEO and the situation was resolved within a week. Staff complimented the senior team for being involved in matters that they cared about and providing an avenue for issues to be raised. This was qualified by the notable increase in freedom to speak up contacts that the trust had received over the last six months. The head of nursing produced a weekly briefing that was communicated at the daily staff huddles to ensure information was shared.

Staff told us that they could easily escalate concerns to the head of service at CMG meetings. Staff on the stroke ward told us that the head of service was easily approached and supportive of staff and patient needs.

Matrons were visible in the ward areas and we saw on two occasions where a matron supported nurses in performing clinical duties due to a shortage in staff. We saw a matron supporting a patient that had got out of bed and assisted them in returning safely, spending several minutes talking to the patient. First names were used, and the matron had a good knowledge of the patient's history.

Staff told us matrons were supportive, but nurse staffing issues often meant that they were utilised across other wards, to support and this could reduce the availability and visibility of matrons in some areas.

Staff told us that they were supported in developing their careers and were supported by managers to do this. However, due to pressure within the service, staff morale was low, particularly around the lower levels of nursing staff. Ward managers seemed to have accepted the reduced staff levels as "normal".

Management of risk, issues, and performance

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

The service had a risk register that included risks identified across the clinical management group (CMG). Risks were discussed and escalated appropriately at regular risk meetings and mitigations discussed. For example, nurse staffing issues had short term and longer-term solutions to mitigate risk. The reintroduction of employing staff from overseas formed part of the long-term solutions, along with the introduction of staff retention initiatives.

We found several ways in which risks could be escalated. Longer term risk was managed through the regular monthly meetings. Risk was reviewed and managed by the senior team at monthly executive board meetings and weekly senior clinical cabinet meetings. These reviews linked into other risk meetings to encourage shared learning across CMG's within the trust. There were also tactical meetings four times a day, with the operations team, which included the senior nurse manager of the day, to consider capacity, flow, clinical risk, elective risks and emergency department and ambulance waits. Any immediate risk could be escalated through a process where a matron or senior nurse could be contacted on a "bleep" or telephone call.

Reduced staffing levels had been included on the risk register and was being mitigated with the use of a priority staffing process to use staff in higher risk areas. Senior nurses were also used to support areas with highest risk. Although there was no data linking staffing levels to a direct increase in incidents, staff told us that they reported staffing issues and that the risk to patient safety had increased.

Medical care (including older people's care)

A longer term plan is being implemented to introduce a single point of access system, with a medical team available to assess and care for patients on their arrival at hospital and move them to an appropriate ward, rather than go via the emergency department (ED). This has not been embedded but progress was being made in developing this system.

Senior staff discussed with us about a plan to develop a general medicine department, with several wards, to enable a better level of overall care for patients. The purpose of this being to improve patient experience and reduce complications of referring to specialist wards or clinicians. The department will have full time consultants and general medicine registrar trainees. This is an initiative being piloted at the trust, with a view to rolling it out nationally. This has started with the employment of a consultant to support and oversee the development of the idea. Staff talked about the differences that the initiative would make and although at early stages, there was a forward momentum being seen across medical care services.

Medical staff were encouraged to take part in quality improvement initiatives and regular clinical audits. We saw that there had been a recent initiative across the trust around delirium and its effects. As part of development, junior doctors told us they had been involved in clinical audits and were encouraged to contribute to new ideas. For example, one doctor told us that they were encouraged to participate in the development of the general medical care model being introduced.

Areas for improvement

MUSTS

Action the trust MUST take to improve:

- The trust must review staffing levels across medical care services to ensure staffing levels are safe and reduce impact on patient safety and staff wellbeing. Regulation 18 - staffing
- The trust must review and provide an action plan for the improvement in providing a consistent and timely in-reach service for the emergency department. Regulation 12 – safe care and treatment

SHOULDS

Action the trust SHOULD take to improve:

- The trust should ensure staff re-assess patient’s venous thromboembolism (VTE) risk after 48-72 hours, as indicated in trust policy. Regulation 12 – safe care and treatment
- The trust should ensure that patients are administered medicines on time and ensure pain relief is monitored to avoid delays in administering. Regulation 12 – safe care and treatment
- The trust should consider reviewing staff availability to provide occupational therapist support at weekends. Regulation 12 – safe care and treatment
- The trust should review the process and staffing of the discharge lounge to improve efficiency in discharging patients and considering patients that require a complex discharge package. Regulation 12 – safe care and treatment
- The trust should review resources and maximise them to support and facilitate timely discharges from wards.

Our inspection team

The team that inspected urgent and emergency care and medical care core services comprised two CQC lead inspectors, two CQC medicines inspectors, and two CQC mental health inspectors. The inspection team also included four specialist advisors who were consultants in emergency care, a registrar in general medicine, a senior emergency care nurse and general medical nurse. The inspection team was overseen by Bernadette Hanney, 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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect