Alexandra Hospital

Evidence appendix

Woodrow Drive
Redditch
B98 7UB

Tel: 01527 503030
www.worcsacute.nhs.uk/our-hospitals/alexandra-hospital-redditch/

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Acute services

Urgent and emergency care

Facts and data about this service

The emergency department (ED) at the Alexandra Hospital provides services 24-hours per day, seven days per week and serves the population of Redditch and surrounding areas. There are approximately 55,000 attendances each year. The number of children attending the ED has decreased from approximately 11,000 to around 7,000 (13% of all attendances) in the last year. This is due to the reconfiguration of paediatric services to another trust site. Ambulances no longer bring seriously ill or injured children to this department.

The ED consists of a minor treatment area with seating and five trolley cubicles, a major treatment area with 10 trolley cubicles and three side rooms, and a resuscitation area with three bays. There is a five-bedded observation ward known as the emergency decision unit and two separate paediatric cubicles. There is also a paediatric observation bay located opposite the nursing station.

The service has been inspected twice in the last year; a comprehensive inspection in November 2016 and an inspection to follow-up concerns in April 2017. The trust has been issued two Section 29A Warning Notices under the Health and Social Care Act 2008. Section 29A Warning Notices are issued when a trust is required to make significant improvement in the quality of care provided. Concerns with the ED were raised in both Warning Notices, which were issued in January and July 2017.

This inspection asked if the ED was safe, effective, responsive, caring and well-led. We looked at each key question and followed up concerns from the Section 29A Warning Notices.

During our inspection, we spoke with 32 members of staff, including doctors, nurses, healthcare assistants, administrative and domestic staff. We also spoke to 12 patients and four relatives. We reviewed 16 patient care records.

Is the service safe?

Mandatory training

There were trust-wide issues with mandatory training data collection that had been occurring since we inspected in November 2016. Previously, the emergency department (ED) was unable to provide information on the number of staff who had completed mandatory training. This was a breach of regulations and the trust was issued a requirement notice for Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 Staffing.

Senior staff in the emergency department (ED) monitored their staff information, which showed compliance did not meet the trust target of 90% in the majority of modules. Not all nursing staff had received basic or intermediate life support training.

During this inspection, senior nurses had local copies of staff training so that they could monitor departmental compliance and did not have to rely on potentially inaccurate trust-wide information.

Both the data provided by the trust and the locally held data showed the overall compliance with mandatory training for ED staff was 65% in September 2017, which was below the trust target of 90%.

There were differences between the trust reported figures for each module and those reported by senior ED staff. However, both datasets showed compliance in all modules was below the trust target, with the exception of nursing staff compliance with health and safety training. Local information reported by senior ED staff was dated as 30 October 2017 and was updated on a weekly basis.

Action had been taken to improve nursing staff compliance and we saw evidence that 16 out of the 23 nurses who were non-compliant were booked onto training sessions by November 2017.

The table below shows the ED did not meet the target for compliance with any of the nine modules included. The figures shown is the percentage of staff that were up to date with that module.

Staff group	Conflict resolution	Equality and Diversity	Fire	Health and Safety	Infection Prevention	Information Governance	Manual Handling	Preventing Radicalisation	Resuscitation (Basic life support)	OVERALL
Medical staff	54%	23%	54%	46%	23%	46%	54%	0%	77%	42%
Nursing staff	80%	38%	74%	87%	51%	77%	65%	38%	78%	65%
Administrative staff	27%	73%	100%	100%	100%	100%	100%	100%	n/a	88%
Average compliance	54%	45%	76%	78%	58%	74%	73%	46%	78%	**65%**

(Source: Routine Provider Information Request (RPIR) –P40 Training Tab)

Nursing staff were required to complete basic life support (BLS), intermediate life support (ILS) and paediatric intermediate life support (PILS) training; however, not all nursing staff were up to date with this at the time of inspection. Nursing staff compliance with BLS was 78%, ILS was 80% and PILS was 80%. All senior nurses had completed an emergency paediatric life support (EPLS) course.

Some nurses (22%) had undertaken advanced life support (ALS) training, in addition to their role requirements.

Medical staff were required to complete life support training up to advanced level (ALS). At the time of inspection, medical staff compliance with BLS was 77%; however, all medical staff had completed ALS and PILS. Medical staff compliance with advanced trauma life support and EPLS was 83%.

All triage nurses had received training to recognise the potential needs of people with mental health conditions. Staff from the mental health liaison team provided this training which included the use of a mental health matrix to determine level of risk and the most appropriate environment for the patient within the ED. Mental health training was also included in the inductions for junior doctors and newly recruited nurses. Training was led by staff from the mental health liaison team and the trust's alcohol liaison nurse.

Safeguarding

After the inspection in April 2017, the trust was issued a Warning Notice for breaching Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment. This was because safeguarding training compliance was below the trust target and the level of safeguarding training for senior staff did not meet national guidance. This remained an area of concern during this inspection.

Medical staff compliance with safeguarding adults and children training did not meet national recommendations

Information provided by the trust on safeguarding training compliance did not reflect the local information held by senior ED staff. The issues with data collection meant the trust did not have an accurate central record of safeguarding training compliance, and therefore could not be assured that patients in the ED were being cared for by staff who could appropriately safeguard them from abuse. For example, information provided by the trust from September 2017 showed medical staff compliance with safeguarding children level 3 was 8%. However, the most up-to-date information provided by senior ED staff showed compliance was 80%.

According to the most up to date information held by senior staff in the ED, medical staff compliance with safeguarding vulnerable adults level 2 remained at 0% since April 2017.

Both datasets showed medical staff compliance was not in line with national requirements. The Royal College of Paediatrics and Child Health Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014 states all clinical staff involved in assessing, planning and treating children and young people should be trained to safeguarding children level 3.

The table below shows information from senior ED staff which was dated as the week commencing 3 November 2017.

Staff group	Safeguarding Children Level 2	Safeguarding Children Level 3	Safeguarding Vulnerable Adults Level 2
Medical staff	100%	80%	0%
Nursing	83%	100%	100%
Overall compliance	91.5%	90%	50%

(Source: Alexandra Hospital emergency department training matrix)

Although compliance did not meet the trust target, all staff we spoke with understood how to protect patients from abuse. They were aware of their responsibilities to report safeguarding concerns and knew whom to contact for advice. Staff described examples of when they had raised safeguarding concerns in the past and knew what actions to take to protect vulnerable adults and children, including those at risk of female genital mutilation.

Senior nurses had access to the child protection information sharing system that was used by GPs and safeguarding teams to monitor children who may be at risk of abuse. Senior nurses could access live information from both local and out-of-area health and social care services. Staff we spoke with described how they would use this system to identify whether children who attended the department were known to social services or may be at risk of abuse.

Triage nurses used an electronic tool to assess the risk of abuse of children if they had concerns, for example, if a child presented with an injury. Nurses would escalate to the on-call social workers if they suspected a child may be at risk of abuse.

If staff had concerns regarding a patient's mental health, they followed the protocol to access a Mental Health Act (MHA) assessment through the mental health liaison team. If patients were distressed or became violent, security was called until the mental health liaison team arrived. There was no evidence that restraint was used in the department. ED staff were not required to use the doctor and nurse holding powers outlined in the MHA, as the department was classed as a public place.

Cleanliness, infection control and hygiene

Cleanliness and infection control policies were generally followed in the ED; however, we observed occasions where staff did not comply with infection prevention and control (IPC) best practice.

Hand hygiene best practice was not always followed to prevent the spread of infection. Staff did not routinely wash or sanitise their hands between patients or when entering and leaving clinical areas. We raised this with senior staff during the inspection and were told all staff would be reminded of the importance of hand hygiene. However, when we returned for the out of hours visit, not all staff were washing or gelling their hands as appropriate. Hand washing facilities, sanitising gel and personal protective equipment (PPE) were available in sufficient quantities in all clinical areas.

We observed nursing staff following the nationally recognised aseptic non-touch technique when caring for patients who required the insertion of cannulas for intravenous therapy. A cannula is a thin tube inserted into a vein to administer medication. Staff described this technique and the importance of its use for infection prevention and control.

The trust's infection prevention and control (IPC) team conducted monthly audits to monitor cleanliness and IPC compliance. Results from September 2017 show the ED achieved 89% compliance. Areas of non-compliance were the cleanliness of equipment, floors and internal décor, and lack of cleaning schedules displayed. During the inspection, all areas we visited were visibly clean and we saw staff thoroughly cleaning equipment. However, cleaning schedules were not always displayed. Some areas had daily cleaning duties displayed, but this did not include logs to show if areas had been cleaned. This meant staff using the clinical areas could not clearly see when or if the area was recently cleaned. Toilet facilities also did not have cleaning logs displayed, which was not in line with Royal College of Emergency Medicine (RCEM) Emergency Department Care Best Practice Guideline 2017.

Staff received up-to-date communication from the trust's IPC team via the departmental IPC link practitioners. The IPC link practitioners were healthcare assistants and nurses whose roles included conducting monthly observational audits to monitor staff compliance with hand hygiene best practice. IPC link practitioners had also given a presentation at a recent induction for newly recruited nurses. Results from September 2017 show ED staff were 100% compliant. However, this was not in line with what we observed during the inspection.

Members of the executive team also conducted departmental spot checks to monitor staff compliance with arms bare below the elbows and appropriate use PPE, such as gloves and aprons. Arms bare below the elbows is an IPC strategy to prevent transmission of infection from contaminated clothing and allows clinicians to thoroughly wash their hands and wrists. Results from the week ending 29 September 2017 showed all staff were observed to be arms bare below the elbows. All staff we observed during the inspection had arms bare below the elbows.

Environment and equipment

The service had suitable premises and equipment and looked after them well. The design, use and maintenance of the facilities kept people safe. Staff knew how to report issues with the environment and equipment and we saw evidence that estates teams responded quickly to resolve problems. Equipment, clinical waste and specimens were stored, labelled and handled appropriately throughout the ED.

Resuscitation equipment was readily available and accessible throughout the department. The three-bedded resuscitation area was fully equipped, including size-appropriate equipment for children. There were also two cubicles opposite the nursing station that were equipped as resuscitation bays, for use during busy periods. Daily and monthly checks of all resuscitation equipment had been conducted. Consumables were rotated so that those approaching their expiry date were highlighted and used first. We observed staff conducting a comprehensive monthly check of equipment and found that issues that were raised during the November 2016 inspection had been addressed. For example, the checklist in the resuscitation room did not previously include chest drains required to treat pneumothorax (traumatic injury to the lungs). During this inspection, we found the chest drains were included on the resus area checklist.

The two paediatric cubicles were secured by swipe-cards to prevent people inappropriately entering areas where children were seen. There was also a paediatric observation cubicle next to the nursing station to allow more close monitoring of children, where required. This cubicle was not secured, but risk had been mitigated by installing swipe-card locks on the internal side of the ED doors to prevent any unpermitted exit from the department. A convex security mirror had also been added to increase visibility and there was a CCTV camera with view of the doors. The waiting area for children was separate from adults and had glass panels so that reception staff could see the area at all times. The children's waiting area also had a separate door leading

directly to the paediatric cubicles so that children could be brought into the department without having to go back through the adult area.

There was a dedicated room for assessing adults and children with mental health conditions. This had recently been refurbished and met all safety standards recommended by the Psychiatric Liaison Accreditation Network (PLAN). PLAN standards include:

- Two doors which open outwards and are not lockable from the inside
- Obscured glass viewing panels to allow staff to observe from the outside whilst maintaining a degree of privacy for the patient
- A panic button or alarm system
- Furniture, fittings and equipment which are unlikely to be used to cause harm or injury to the patient or staff member
- No ligature points

We observed this room being used appropriately for mental health assessments during our inspection.

The layout of the ED supported patient flow as it was in close proximity to the main diagnostic imaging department, the ambulatory emergency centre and the frailty assessment unit. The diagnostic imaging department was directly adjacent to the ED with adjoining doors so patients could be rapidly taken for x-rays and scans.

During this inspection, we observed IT issues being reported and resolved promptly. Systems used across the hospital had been affected by a temporary power cut during our visit. Staff knew how to report the problem and who to contact for support. The IT team attended the department within an hour and problems were resolved with minimal impact to patients or the service delivery.

Assessing and responding to patient risk

Patients were not consistently assessed within 15 minutes of arrival. However, from November 2016 to October 2017, the median time patients waited for an initial assessment was nine minutes. This was within the limit of 15 minutes set by the RCEM (Initial assessment of emergency department patients - 2017). Despite this, data from January to November 2017 showed performance varied from 54% to 97% of patients assessed within 15 minutes. This meant the ED was not consistently in line with the RCEM and Royal College of Nursing (RCN) guidance that states 95% of patients should receive an initial clinical assessment within 15 minutes of arrival.

When triage times exceeded 15 minutes, emergency nurse practitioners (ENPs) reviewed patients who were waiting and selected those who they could see and treat. For example, patients with minor injuries. We observed this process in practice during our inspection as temporary issues with IT systems meant patients were waiting longer than 15 minutes for initial assessment. ENPs identified, triaged and treated patients with minor injuries to minimise delays and allow triage nurses to prioritise more seriously ill patients.

Patients were triaged using the nationally recognised Manchester triage tool to conduct initial clinical assessments of patients' acuity and prioritise based on clinical need.

The triage process also involved streaming patients to other co-located services, where appropriate. For example, triage nurses contacted the hospital's ambulatory emergency centre (AEC) if a patient was assessed as suitable. The AEC accepted patients who could be treated as a medical day-case, to prevent the need for hospital admission. During this inspection, we observed that the pathway was embedded and used effectively; patients were appropriately identified and streamed to the AEC.

Triage nurses could also stream patients to the out of hours GP service that was located within the ED. However, we were told that on average one patient per night was deemed by the GP as an

inappropriate referral and had to be sent back to the ED for further treatment. This meant these patients experienced unnecessary delays to treatment. We asked to see information on inappropriate referrals to the out of hours GP, but staff were unable to provide this.

Patients brought in by ambulance waited in the corridor while ambulance crews handed over to ED staff. If there were delays in clinical assessment or the availability of cubicles due to the department being busy, patients waited on trolleys in the corridor until a suitable clinical area was available. Triage nurses or the hospital ambulance liaison officer (HALO) supervised these patients until they were taken to an appropriate clinical area.

Previously, patients spent long periods in the corridor due to capacity issues across the hospital. During this inspection, there was only one occasion when patients were kept waiting in the corridor. This was due to three ambulances arriving in quick succession meaning there was a delay in ambulance handover. On this occasion, the patients were promptly assessed and safely managed. This meant the patients waited in the corridor for no longer than ten minutes before being allocated to an appropriate clinical area.

Staff we spoke with throughout the inspection told us that use of the corridor had reduced, but patients still waited in the corridor upon arrival by ambulance between three to four times per week when the department was busy. We asked to see data to show how long these patients spent in the corridor; however, the trust were unable to provide us with this. We therefore could not be assured that patients who were brought in by ambulance were not spending prolonged periods in the corridor upon arrival. We also could not be assured that the ED were monitoring the time these patients waited in the corridor.

The data the trust did provide was collected from their electronic system which tracked patients through the department. A patients' location, such as a numbered majors cubicle, was logged onto the electronic system once they were triaged or handed over from ambulance crews. The data showed that no patients spent time in the corridor after ambulance handover. This included those who were waiting for an available hospital bed after a decision to admit. Staff also told us that this was the case. This was a significant improvement since the inspections in November 2016 and April 2017 when patients frequently waited in the corridor for hospital beds, due to poor patient flow and lack of bed capacity across the hospital. Routine use of the corridor to care for patients over long periods of time was previously highlighted as a major patient safety concern.

The nurse in charge and HALO monitored expected ambulance arrivals using the ambulance service's electronic dashboard. We were told that a cubicle was reserved in response to an expected influx of ambulances, so that patients could be taken to private areas to be assessed. However, we were unable to observe this on inspection as there were no occasions where patients arriving by ambulance could not be taken to an appropriate clinical area for assessments.

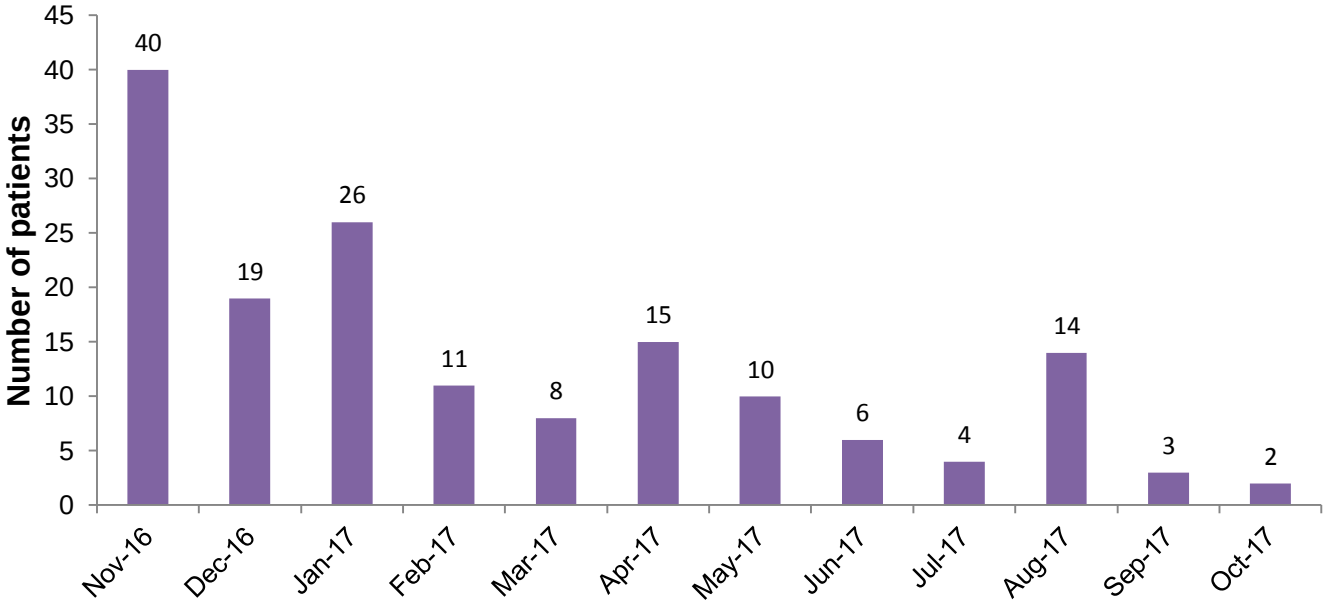
During previous inspections, it was highlighted that the handover process for patients arriving by ambulance could become unclear when the department was busy as staff were not always sure of who was caring for each patient in the corridor. When the department was busy during this inspection, we observed the nurse in charge allocating expected ambulance arrivals to the triage nurse and a nurse in the major treatment area, as a cubicle was available for handover. The HALO was not on duty at this time. We did not observe any occasions when there was more than three patients in the corridor.

There was no set protocol or written criteria for assessing patients' suitability for waiting in the corridor. This was a risk if handover was taken by a nurse as not all nurses were trained to triage patients. Nurses who were not triage trained had received a teaching session with emergency nurse practitioners (ENPs), but had not received any other triage training. We raised this with senior staff at the time of inspection and were advised that nurses escalated any concerns to the nurse in charge who made decisions based on clinical judgement. We did not observe any occasions where patients waited in the corridor for over ten minutes. Nurses we spoke with could give examples of patients who they would deem unsuitable for waiting in the corridor, such as those with dementia or those who had suspected spinal injury.

Delays in ambulance handovers had improved. For the six weeks prior to this inspection, an average of 8% of patients had to wait for more than 30 minutes before being handed over to ED staff. This was an improvement since the inspection in November 2016 when 15% of patients waited over 30 minutes. Patients spent on average nine minutes waiting to be handed over to ED staff from November 2016 to October 2017. This was in line with RCEM recommendations that state ambulance handover should take no longer than 15 minutes.

There had also been an improvement in the number of patients who were kept waiting for over 60 minutes before being handed over to ED staff. If a patient is kept waiting under the care of the ambulance crew for one hour or more, this is known as a black breach. The graph below shows the number of patients per month who were kept waiting for over 60 minutes before being handed over to the ED staff.

Number of black breaches



When a patient self-presented to the department, receptionists logged their details and escalated to clinicians if a patient required urgent attention. Receptionists had written criteria that outlined 'red flags', such as chest pain, traumatic injury or signs of a stroke. This was on display in reception. We observed receptionists appropriately escalating patients to clinicians. For example, a patient self-presented to the department with breathing difficulties and a history of asthma. This patient was flagged to the triage nurse and was admitted to the resuscitation area for monitoring within 12 minutes. All reception staff we spoke with could describe when they would escalate patients to clinicians. They had an emergency call bell to use if a patient collapsed or in an emergency.

Staff used the National Early Warning Score (NEWS) to monitor and identify patient deterioration. This included determining a patient's risk of sepsis. Patients were screened for sepsis at each clinical assessment during their visit to the ED. Suspected or confirmed cases of sepsis were managed using the Sepsis 6 care bundle. Sepsis 6 is a nationally recognised six-step care bundle that should be implemented within one hour. The steps are:

- Administering oxygen
- Taking blood cultures
- Giving intravenous (IV) antibiotics
- Giving IV fluids
- Taking lactate measurements
- Monitoring urine output

We tracked two patients with suspected sepsis through their attendance in the ED and saw that they were screened and managed appropriately using Sepsis 6. Staff escalated these patients to medical staff and IV antibiotics were given within one hour.

The ED did not treat seriously ill children, as the hospital did not have appropriate inpatient facilities to allow admission. It was previously highlighted that the trust's guidance to the ambulance service was unclear and children were inappropriately brought to the department. During this inspection, we found that communication with ambulance crews had improved and there had been no inappropriate transfers of children in the three months prior to the inspection.

The Paediatric Early Warning Score (PEWS) was used to aid early detection of a deteriorating child. Nursing staff categorised severity of illness using PEWS and took action in response to specific triggers. PEWS was used and escalated appropriately during this inspection. If a seriously ill child was brought to the department by a parent or relative, there was a protocol in place for transfer to Worcestershire Royal Hospital. Staff were trained to respond to paediatric emergencies and followed a child resuscitation plan to stabilise a patient for transfer, where appropriate.

Paediatric resuscitation was led by a senior member of medical staff who was trained to an advanced level in paediatric life support. If an emergency occurred out of hours, the most senior on-call doctor attended the department. A child in ED had not required resuscitation in the 12 months prior to the inspection.

During both inspections in November 2016 and April 2017, actions were not taken in response to the ED becoming 'overwhelmed'. The status of the ED was determined by a safety matrix that used information on patient numbers and complexity, ambulance arrivals and staffing levels to assess if the conditions promoted patient safety. The categories were normal, busy, critical and overwhelmed. However, there was no guidance or escalation criteria for staff to follow if the department became 'overwhelmed' or 'critical'.

A 'Surge and Escalation Management Protocol' had been developed which included actions for ED senior clinicians to take in response to each category on the safety matrix. However, it was unclear if the protocol had been implemented as the document was not dated and staff we spoke with were not sure if it had been introduced. From August to October 2017, there were 31 days when the ED had reached 'overwhelmed' status.

The status of the ED was reported to the bed management team every two hours via an electronic system. Bed management meetings took place four times per day and were attended by senior staff from across the hospital, including ED. We observed two of these meetings and saw staff worked together to review capacity and identify ways to improve flow and minimise the impact on patients in the ED.

The ED status was calculated using a safety matrix which included the number of patients in each area of the department, the number of patients arriving by ambulance and medical staffing levels. Senior nurses submitted this information every two hours and escalated increasing patient numbers to clinical leads in between the two-hour intervals. Clinical leads contacted the bed management team to identify safe ways to manage the additional patients across the hospital, but this process was not formalised at the time of inspection.

Staff had access to 24/7 mental health support for patients of all ages. There was a mental health liaison team based in close proximity to the ED. The liaison team was staffed by the local mental health trust and was available from 8am to 10pm. Data from November 2016 to September 2017 showed the mental health liaison team responded within one hour to 98% of referrals. We observed the mental health liaison team attending the department within thirty minutes during this inspection.

Out of hours, staff contacted the mental health crisis team to provide assessments; however, referrals were not always responded to in a timely way. The crisis team worked across Worcestershire so response times varied depending on their capacity and workload.

The ED assessed patients using the mental health matrix and those who were deemed medium to high risk were allocated a bay in the department's emergency decision unit (EDU) where they could be supervised by a nurse at all times. Staff then contacted the mental health liaison team the following morning. Patients who were deemed as low risk could be sent home, if medically appropriate and the mental health liaison team would follow-up via telephone or invite them for a face-to-face assessment.

Nurse staffing

Nurse staffing levels within the department did not always meet national guidance; however, improvement had been made since previous inspections.

After the November 2016 inspection, the trust was issued with a requirement notice for breaching Regulation 18 HSCA (Regulated Activities) Regulations 2014 Staffing due to having insufficient numbers of suitably qualified, skilled and experienced nurses to care for the patients attending ED. During this inspection, five newly recruited nurses had commenced in their roles and a further three nurses had confirmed start dates. In total, there were 12 nurses at various stages in the recruitment process.

From November 2017, effective recruitment meant the ED would be in line with standards set by the RCN and the Royal College of Paediatrics and Child Health for paediatric EDs of their size. However, at the time of inspection, they were not meeting national guidance as only one registered children's nurse was employed.

The ED mitigated the risk of having an insufficient number of paediatric-trained nurses by providing other nurses with the opportunity to gain paediatric competencies. Triage nurses had completed a five-day course at a local university in paediatric health assessment. In addition, 35% of nurses were trained in emergency paediatric life support (EPLS) and paediatric intermediate life support (PILS), which meant there was at least one nurse who was trained in child resuscitation on duty at all times. Staffing rotas we reviewed confirmed that this was the case.

Staffing levels and skill mix were determined using a 'Safer staffing' app. Staffing levels were reported at the hospital-wide capacity management meetings four times a day. A staffing co-ordinator attended these meetings so that nursing staffing across the hospital could be reviewed and nurses could be flexed to other areas, where appropriate.

We reviewed nursing staff rotas for the three months prior to the inspection and found that staffing levels generally met RCN guidance; however, there were occasions when the recommended ratios were not met. For example, during the inspection the ED was short of three nurses due to sickness and agency staff not arriving for shifts. This did not allow the recommended nursing ratio of one nurse to every four patients. Staffing levels also did not always ensure there was one nurse to every two patients in the resuscitation area, in line with RCN guidance. Also, current staffing levels were not displayed in the department.

Agency and bank staff were used to fill shifts that were short-staffed. There was at least one member of agency or bank staff on every shift from July to September 2017. The majority of agency and bank nurses who were used worked regularly in the department and had been given an induction and orientation around the department. One agency nurse we spoke with said they had returned to the ED after a period of three months and was given another induction upon return. The ED was found to be compliant with ensuring all agency staff received an induction during a spot-check conducted by an executive director in September 2017.

Six emergency nurse practitioners (ENPs) were employed by the ED. Two ENPs worked in the ED each day. ENPs worked from 8am to 10pm during the week and from 8am to 12am at the weekend.
There was a vacancy rate of 5.9 whole time equivalent (WTE) nursing staff and a reported sickness rate of 3.4%. This was lower than the national average of 5.1%.

We observed nursing handover to be robust. Staffing issues, patient acuity and associated risks were discussed. There was a standardised 'safety huddle' sheet for use at handover; however, this was not always used.

Medical staffing

Medical staffing was identified as a safety concern at previous inspections and had not improved during this inspection. There was insufficient medical cover to provide consultant presence in the department for 16 hours a day, as recommended by RCEM. Consultants worked from 9am to 7pm, Monday to Friday and from 9am to 8pm at weekends. Outside of these hours, they worked on-call.

There were two substantive consultants in post; one consultant was the clinical lead and the other was the clinical governance lead. Two additional consultants worked in the department as long-term locums. Senior staff in the ED had recognised that medical staffing was a risk and were trying to recruit substantive consultants. The trust had been approved to recruit two more consultants to the urgent care division; however, this was also to cover the ED at Worcestershire Royal Hospital. We saw no improvement in consultant staffing levels since the April 2017 inspection.

Medical staffing levels at night were not sufficient to ensure patient safety was maintained at all times. The ED was staffed by two to three middle-grade doctors from 7pm to 12am, and two middle-grade doctors from 12am onwards. This meant that if one doctor was called to attend a patient in the resuscitation area, only one middle-grade doctor was available to care for all other patients in the department. Staff we spoke with did not always feel that this was safe.

The ED had vacancies for two whole time equivalent (WTE) consultants and three WTE middle-grade doctors. The department had six middle-grade doctors at the time of this inspection; three of which were locum. An overseas recruitment programme for middle-grade doctors was ongoing and candidates had been short-listed; however, there were no definitive start dates or new appointments had been made.

There had been an improvement since the inspection in April 2017 in the levels of medical staff training in paediatric life support. At the time of inspection, all medical staff had completed EPLS training.

There was a structured medical handover between each shift. The handover included details of all patients in the department at the time and any associated risks and/or urgent needs. We observed the daily board round in ED where medical staff reviewed each patient in the department. Discussions were robust and involved medical staff of all grades, from junior doctors to consultants. Each patient's medical, mental and social wellbeing was discussed.

Records

Staff kept appropriate records of patients' care and treatment. We reviewed 16 patients' records and found they were generally clear, up-to-date and available to all staff providing care. However, there were four sets of notes that contained entries where the staff members' name and signature was unclear. This meant it could be difficult to establish which staff member had completed that episode of care.

Patients' details were recorded on a computer system when they arrived so that staff could monitor how long they had been waiting and the assessments they had received. This system could be accessed by all ED staff and by staff in the ambulatory emergency centre (AEC) and frailty assessment unit (FAU). This meant AEC and FAU staff could review patients who were referred by the ED or those who were waiting, to assess their suitability for the units.

The computer system was used to generate paper records once a patient registered so that staff could record the care and treatment given. For patients who arrived by ambulance, paper copies of their ambulance notes and handover were incorporated into their ED records.

When not in use, paper records were kept in a trolley next to the nurses' station that was supervised at all times. Paper records for patients in the emergency decision unit (EDU) were kept at the nurses' station in the unit; however, we observed three occasions during the inspection when there was no staff member present in the EDU and notes were accessible. This meant there was a risk that other people could access patients' personal information.

Once patients left the ED, their paper records were scanned onto the computer system and discharge summaries were sent to patients' GPs electronically. Paper records were then securely shredded.

Risk assessments were completed appropriately in most of the records we reviewed. There were three sets of notes where Waterlow scores had not been calculated when a patient had been in the department for over four hours; however, each of the patients had a body map completed which identified any areas of skin damage. Waterlow assessments are used to determine the risk for the development of a pressure sore in a given patient. For each patient who had not had a Waterlow assessment, staff had assessed and recorded their skin integrity, but not calculated their score. We did not see any examples where pressure area care was not delivered as required. All other risk assessments, such as falls and bed space assessments were completed in all records as appropriate.

All records we reviewed contained information on patients physical, mental and social needs. The mental health liaison team completed assessments that included patients' biological, psychological and social factors. After an assessment, they developed an individualised care plan for the patient. The care plan was incorporated into the patient's ED notes so that ED staff had access.

ED staff gave examples of giving advice and using principles of the Mental Capacity Act 2005 and Mental Health Act if a patient attempted to discharge themselves or refused treatment. Staff also knew situations where the police might have to be contacted if a patient was a risk to themselves or others.

Patients who were prescribed antimicrobials had the clinical indication, dose and duration of treatment documented in their records.

Medicines

Medicines were not always stored in line with trust policy. There were gaps in fridge temperature recordings and intravenous fluids were not risk assessed for tamper proof storage.

There were seven dates in September 2017 and nine dates in October 2017 where temperatures of the medicines fridge in the resuscitation area had not been recorded. This meant we could not be assured that medicines were always stored within recommended temperature ranges. This was a safety risk as the effectiveness and shelf life of certain medicines can be affected if temperatures are not between two to eight degrees Celsius. We raised this with senior staff during the inspection. On dates where temperatures fell outside of the recommended range, pharmacy advice had been sought as appropriate.

There was also a safety issue regarding storage of fluids for intravenous (IV) use in the resuscitation area. The IV fluids were kept unlocked for ease of access in an emergency; however, this had not been risk assessed for tamper proof storage. This meant staff could not be assured that the fluids were safe for use. We raised this with senior staff during the inspection and were advised that a risk assessment would be completed.

Other than the fridge temperatures and IV fluids in the resuscitation area, all other medicines were stored safely in the ED. A new medicine storage room where medicines were stored safely behind locked doors was only accessible to authorised staff. Separate cupboards for the storage of penicillin and penicillin-related antibiotics were clearly marked to ensure clinical staff were aware of the importance of checking for penicillin allergy.

Medical staff followed the trust policy when prescribing and administering medicines, including antibiotics. When patients were prescribed an antibiotic, they had a microbiological sample taken and their treatment was reviewed based on the results. Allergies were clearly documented in patients' notes. The screening tool used for suspected sepsis included details of prescribed antibiotics, oxygen and fluids required for initial treatment.

The trust was previously issued with a requirement notice for breaching Regulation 12 HSCA (Regulated Activities) Regulations 2014 Safe care and treatment, due to lack of systems in place to record medicines administered to patients by ambulance crews. This posed a risk of repeat doses being given by doctors, as they may be unaware of the medicines already administered. Improvement had been made at the inspection in April 2017 and a printer had been installed so that a paper copy of the ambulance records could be added to the patients' ED records. During this inspection, we found that this system was embedded and patients' ambulance notes were routinely incorporated when their ED record was generated. There had been no related incidents of repeated doses reported since this system was introduced.

All medicines seen were in date and staff told us they regularly checked medicines expiry dates. Controlled drugs were stored securely and checks were recorded every night to ensure stock levels were accurate. We observed nursing staff administering controlled drugs during the inspection and found that the correct procedures were followed.

Incidents

Learning from serious incidents was not always implemented, reviewed or shared effectively. However, there had been some improvement in incident investigation since the November 2016 inspection.

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in the ED that met the reporting criteria set by NHS England, from November 2016 to October 2017. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Two SIs were reported as treatment delay meeting SI criteria and one was sub-optimal care of a deteriorating patient.

All three SIs had been investigated using root cause analysis, in line with the Serious Incident Framework 2015. This was an improvement since the inspection in April 2017 when investigations were not investigated in line with national guidance. We reviewed the investigations of all three SIs and found the root causes and contributory factors were identified, recommendations had been made and action plans were created.

However, two of the action plans had not been updated since they were created and there was no evidence to show if recommended changes had been made; despite having completion dates from August to October 2017. SIs were not always discussed in departmental governance meetings, and although SIs were discussed in other meetings, there was no evidence of reviewing and updating action plans. Reports were disseminated to divisional management, but there was not always a clear audit trail to show that areas for learning were cascaded to all staff. We therefore could not be assured that learning from incidents was embedded into service delivery.

Also, two of the reports were delayed by one month with no reason given.

The SI investigation process now included 'round-table' meetings where all relevant members of the clinical team got together to discuss the incident and areas for learning. We were told that information from these meetings was shared with staff via email, during team meetings and printed in the staff room; however, staff we spoke with during the inspection could not describe the recent SIs or what learning had been implemented as a result.

From November 2016 to October 2017, there were no reported incidents that classified as never events in the ED. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

Mortality and morbidity (M&M) reviews remained an area of concern during this inspection. In January 2017, the trust was issued a Section 29A Warning Notices that required them the trust to make significant improvements related to the lack of formal M&M meetings in ED. At this inspection, we found M&M meetings were taking place; however, the quality of review was poor.

The M&M minutes provided lacked detail and there was little evidence of actions or learning as a result. We were told emails were disseminated to staff with details of learning; however, staff we spoke with were unable to recall any recent learning from deaths. Also, attendance at the meetings was poor, with only two staff members recorded as attending the meeting minutes we reviewed. We were therefore not assured that deaths within the ED were being effectively reviewed to provide learning opportunities or that information was effectively communicated to staff.

A trust-wide learning from deaths policy had been developed in line with the National Quality Board Guidance on Learning from Deaths. The policy outlined the criteria for deaths to be reviewed, methods of investigation, engagement with bereaved families and carers and guidance for learning and sharing. However, meeting minutes showed the ED was not adhering to this policy and senior staff we spoke with were unaware that it had been developed.

There was a culture of incident reporting in the department. All staff we spoke with knew how to report incidents and what should be reported. They gave examples of receiving feedback after reporting an incident.

Duty of candour was followed in the ED. Staff could describe their responsibilities and we saw evidence that they informed patients when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety thermometer

The NHS Safety Thermometer is a national tool used to record the prevalence of patient harm. It provides information for staff to monitor their performance in delivering 'harm-free care'. Measurement is intended to focus attention on reducing patient harm.

Data collection takes place one day each month – a suggested date for data collection is given but departments can change this. Data must be submitted within 10 days of suggested data collection date. The ED submitted data from the five-bedded emergency decision unit.

Data from the NHS Safety Thermometer showed that the ED reported one new pressure ulcer, one fall with harm and no new catheter urinary tract infections from October 2016 to October 2017.

(Source: NHS Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

There had been some improvement in the evidence-based care and treatment delivered in the emergency department (ED) since the inspection in November 2016. Audits were now being

undertaken and there had been some action to improve as a result. However, this was not consistent and not all audits had been used to identify or implement actions to improve.

Previously, there were no evidence-based proformas or clinical pathways in use; therefore, we could not be assured that patients received care in line with best practice. During this inspection, improvement had been made and clinical pathways were in place for serious conditions, such as heart attacks and strokes. Also, medical staff used ultrasound-guided regional block anaesthesia when treating patients with fractured hips, which was in line with national guidance. Staff were aware of pathways to follow and could demonstrate how to access this information.

The ED had taken part in national clinical audits and had implemented an annual programme for internal clinical audit in September 2017. This was an improvement since the inspection in November 2016 when participation in audits was limited. However, audit results show compliance with evidence-based practice was variable and actions to improve were limited.

The Trauma Audit and Research Network (TARN) 2017

The ED submitted data to TARN to monitor compliance with National Institute for Health and Care Excellence (NICE) guideline NG39: Major trauma: assessment and initial management. In 2017, results showed that the ED performance was variable compared to the national average.

Measure	This ED	National average
Proportion of appropriate patients given CT scan within 60 minutes of arrival	20%	51%
Patients reviewed by a senior doctor on arrival	100%	56%
Rapid access to specialist major trauma care within 12 hours of referral	50%	68%
Proportion of patients with Glasgow Coma Score over nine given airway management within 30 minutes of arrival	50%	39%
Proportion of patients with Injury Severity Score over eight given rehabilitation prescription	62%	31%

(Source: The Trauma Audit and Research Network – Major Trauma Dashboard 2017)

Internal audit of timeliness of CT scan requests and reports

The TARN audit showed that the timeliness of CT scans for trauma patients was worse than the national average. In June 2017, the ED had conducted a re-audit of the timeliness of CT scans and reporting for all patient groups. Results in the table below show that the department was not meeting national targets for CT requesting and reporting within one hour.

Measure	Result	Target
CT requested within one hour	36%	100%
CT reported within one hour	76%	100%
CT requested within one hour out of hours	22%	100%
CT reported within one hour out of hours	67%	100%

(Source: Alexandra Hospital emergency department internal audit)

Actions to improve included improving medical staffing levels and using an alert on the electronic system to notify ED staff when reports were ready. However, there was little evidence to show how these actions were being implemented or monitored to ensure improvement.

Internal audits of sepsis screening and management

The ED completed audits to monitor compliance with the NICE guideline NG51 Sepsis: recognition, diagnosis and early management. This included monitoring compliance with sepsis

screening and use of the Sepsis 6 care bundle. Results showed the department was improving and they screened 100% of appropriate patients in October 2017. However, the percentage of patients who received all elements of the Sepsis 6 care bundle within one hour remained below the national standard. The table below shows results for the three months prior to inspection.

Month	Percentage of patients with NEWS of 5 or above screened for sepsis	Percentage of patients with suspected sepsis who had Sepsis 6 completed within one hour
August 2017	96%	11%
September 2017	97%	38%
October 2017	100%	60%

(Source: Alexandra Hospital emergency department internal audit)

Work was ongoing to improve compliance with sepsis management, in line with NICE NG51. For example, the ED sepsis lead nurse had introduced a red tray system where patients' notes were placed if they were suspected to have sepsis. The red tray was on the nursing station, which was highly visible to medical and nursing staff. This meant all staff could clearly and quickly see if any patients in the department were suspected to have sepsis, to prioritise and implement Sepsis 6 within one hour. Results from August to October 2017 (table above) show compliance had improved since the red tray was introduced.

Patients were assessed using evidence-based tools, such as the National Early Warning Score (NEWS), Paediatric Early Warning Score (PEWS) and the Bournemouth frailty tool. Staff used the Bournemouth frailty tool to determine if patients were suitable for referral to the frailty assessment unit. Audits of the use of NEWS in ED showed patients were appropriately assessed with scores calculated and escalated correctly. Compliance was from 90% to 100% for the three months prior to inspection.

Mental health assessments, interventions and treatments offered were in line with NICE guidance Patients who were suspected to be experiencing depression were referred to the mental health liaison team. Patients who were considered to have low-risk mental health symptoms who were unwilling or unable to see the mental health liaison team during their attendance were followed up the next day.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs whilst in the ED. Staff made adjustments for patients' religious, cultural and other needs.

Nursing staff conducted care and comfort rounds that included offering patients food and drink. All patient records we reviewed showed rounds were completed every two hours and food and drinks consumed were documented. This was an improvement since November 2016, when rounds were not consistently being completed every two hours.

We observed staff providing patients and visitors with food and drinks throughout this inspection. There was a drinking water dispenser in the EDU for patients and visitors to use. Patients and visitors we spoke with had been offered food and drink.

Pain relief

Staff monitored patients' pain regularly and used tools to assess pain in patients with communication issues, such as patients who were unable to speak or those with dementia. Pain was included in the two-hourly nursing care and comfort rounds.

Throughout the inspection, we observed staff asking patients if they were in any pain and providing analgesia in a timely way, where required. Nurses were able to administer simple pain

relief under a patient group direction, which permitted suitably trained staff to supply prescription-only medicines to groups of patients, without individual prescriptions.

Children were offered appropriate and prompt analgesia, in line with RCEM Management of pain in children. We observed children's pain being assessed and pain relief given during their initial clinical assessment. Triage nurses ensured they complied with national guidance for administering analgesia to children by obtaining a second signature from a registered prescriber prior to administration.

Pain relief was clearly recorded in patient notes.

Patient outcomes

The department took part in national clinical audits to monitor patient outcomes and benchmark their service against others; however, actions to improve were not always implemented or monitored. Although there were areas where the ED performed similar to the national average, results generally did not meet national standards. The results for the 2016/17 RCEM audits are shown below.

RCEM Moderate and acute severe asthma audit

The ED did not meet any of the national standards in the RCEM audit of moderate and acute severe asthma in 2016/17. They performed in the lowest 25% of departments in eight out of the 15 standards measured; seven of which were defined as fundamental standards, which meant RCEM recommends they should be in place for all patients. Results are shown in the table below, in red where the ED performed in the lowest 25% of departments, yellow where they were similar to other departments and green where they performed in the highest 25% of departments.

Standard	Standard requirements	This ED	National Standard
Standard 1a	Oxygen given on arrival to maintain sats 94-98%	14%	100%
Standard 1b	Oxygen prescribed on arrival to maintain sats 94-98%	0%	80%
Standard 2a	Vital signs measured and recorded on arrival at the ED	42%	100%
Standard 2b	Patients with abnormal vital signs have a further set of vital signs recorded within 60 minutes	21%	80%
Standard 3	High dose nebulised β_2 agonist bronchodilator given within 10 minutes of arrival	4%	100%
Standard 4	Add nebulised ipratropium bromide if there is a poor response to nebulised bronchodilator therapy	76%	100%
Standard 5a	Steroids given within 60 minutes of arrival (acute severe)	0%	100%
Standard 5b	Steroids given within 4 hours (moderate)	0%	100%
Standard 6	Intravenous magnesium given to adults with acute severe asthma who do not respond well to bronchodilators	13%	80%
Standard 7	Evidence of consideration given to psychosocial factors in adults prior to discharge	18%	50%
Standard 8a	Evidence of assessment before discharge that the patient's inhaler technique is satisfactory	0%	80%
Standard 8b	Evidence of assessment before discharge that the patient's inhaler type is satisfactory	0%	80%
Standard 9	Discharged patients have oral prednisolone prescribed	39%	100%
Standard 10	Written discharge advice given to the patient	0%	80%
Standard 11	GP or clinic follow-up arranged according to local policy for discharged patients within 2 working days	10%	80%

There was no evidence of action taken to improve patient outcomes based on the RCEM moderate and acute severe asthma audit. During this inspection, we observed a patient who presented to the department with asthma was given oxygen and a nebuliser within 15 minutes of arrival.

RCEM Consultant sign off audit 2016/17

The ED did not meet any of the national standards in the RCEM consultant sign-off audit in 2016/17. This audit monitored the percentage of patients from certain higher-risk groups who had a senior medical sign-off prior to admission, transfer or discharge, in line with guidance.

The audit results are shown in the table below. Yellow indicates where the ED performed in line with other departments and red indicates where they performed worse than other departments.

Standard	Patient group	This ED	National standard
Standard 1	Patients aged 30 years and over with chest pain	7%	100%
Standard 2	Children aged under one year old with fever	0%	100%
Standard 3	Patients making an unplanned return to ED for the same condition within 72 hours	19%	100%
Standard 4	Patients aged 70 years and over with abdominal pain	0%	100%

The ED also did not meet any of the national standards for senior doctor sign-off for these groups of patients.

RCEM Severe Sepsis and Septic Shock Audit 2016/17

In the RCEM Severe Sepsis and Septic Shock Audit for 2016/17, the ED did not meet the national standard in ten of the thirteen measures. However, performance was similar to or better than other departments in each measure. The standards where the ED performed better than most other departments were:

- Standard 1: A complete set of vital signs recorded on arrival
- Standard 3a: Oxygen given to 50% of patients within one hour of arrival
- Standard 3b: Oxygen given to all patients within four hours of arrival
- Standard 4a: Serum lactate measured within one hour of arrival for 50% of patients
- Standard 6a: Intravenous fluids given within one hour of arrival for 75% of patients
- Standard 6b: Intravenous fluids given within four hours of arrival for all patients
- Standard 7a: Antibiotics administered within one hour of arrival for 50% of patients

Actions to improve were monitored by the ED sepsis lead nurse on an ongoing basis as part of the trust-wide sepsis group and monthly sepsis audits.

Sepsis Commissioning for Quality and Innovation (CQUIN) audit

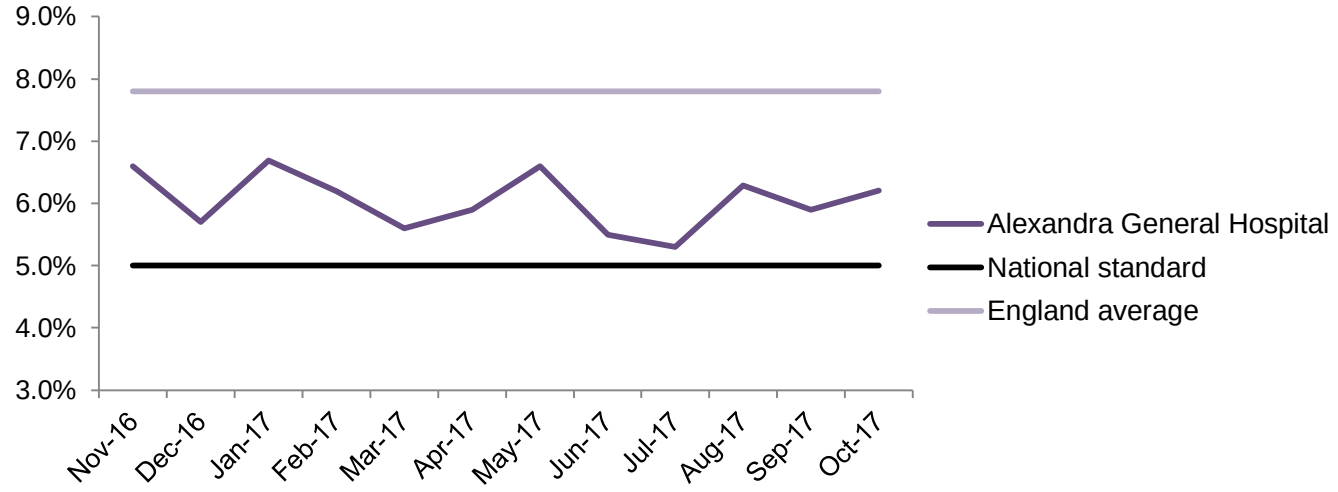
The ED also monitored their compliance with national guidance for sepsis by participating in Sepsis CQUIN audits. Results from September 2017 showed the ED achieved 100% for patients with NEWSs of five or more assessed for sepsis using the recommended screening tool. They were found to be compliant with five elements of the 'Sepsis 6' bundle, with the only area of non-

compliance being lack of urine output measurements commenced within one hour. Results and actions to improve had been shared with staff in the ED and the notes we reviewed for patients with suspected sepsis had urine output measurements recorded within one hour.

Senior nurses had produced a statement of intent in July 2017 outlining their roles, which included reporting audit outcomes to the trust's quality assurance hub and communicating feedback to ED staff. On inspection, we found that audits were in place. However, senior nurses were not all aware of results, feedback or actions to improve as a result of audits.

The rate of patients re-attending the ED did not meet the national standard. Re-attendance rate within seven days for the same condition is used as an indicator of patient outcomes and the Department of Health states this should be no more than 5% of patients. From November 2016 to October 2017, on average 6% of patients had an unplanned re-attendance within seven days. Although this did not meet the national standard, the ED performed better than the England average for this period, which was 7.8%. The table below shows the ED performance compared to the national standard and the England average performance over this time period.

Unplanned re-attendance rate within seven days



(Source: NHS Digital - A&E Quality Indicators)

Competent staff

The majority of medical staff in the ED received annual appraisals to review their performance and clinical competence. 75% of medical staff eligible for an appraisal had received one, 12% had a confirmed appraisal dated booked and the remaining 13% of staff were new starters that were due to complete their preceptorship programmes. The trust target was 90% compliance.

In November 2016, the trust did not provide evidence to show medical staff in the ED had been revalidated to practice by the General Medical Council (GMC). This meant we could not be assured that doctors met the GMC professional standards. During this inspection, the trust provided evidence to show doctors working in the ED had undergone revalidation with the GMC within the previous five years. The information provided by the trust showed they were monitoring medical staff revalidation and those who were approaching the date for renewal were highlighted.

The department was able to provide information on nursing staff appraisals. At the time of inspection, 88% of nurses had received an appraisal within the previous 12 months, or had ongoing performance reviews as part of their preceptorship programme as a newly qualified nurse. A further 12% had their appraisals booked for the three months after this inspection.

There were monthly professional development review (PDR) meetings with managers to review competence, skills and knowledge; however, nurses did not routinely receive clinical supervision.

Informal teaching sessions were held, but there was no formalised, protected time for clinical supervision to review nurses' competence or learning needs.

Where learning needs were identified in PDRs, staff had access to training and education. For example, while recruitment for paediatric-trained nurses was ongoing, five nurses who were not paediatric-trained had attended a five-day course at a local university to gain competence in paediatric health assessment. The induction for all nurses included a session on how to recognise a sick child, using PEWS and assessing pain in children.

Eight nurses had also completed the Emergency Nurses Association Trauma Nursing Core Course (TNCC) and a further four were scheduled to attend in February 2018. The TNCC provides nurses with skills for identifying, assessing and caring for trauma patients, in line with national guidance. We spoke with nurses who had attended the TNCC and all felt that it had improved their practice. They described examples where they had felt confident applying their skills.

In September and October 2017, intensive care and trauma consultants from across the trust had attended the ED to provide scenario training. This included simulation of paediatric resuscitation to maintain staff skills as the department no longer received seriously ill children via ambulance. Seriously ill children could still be brought to the department by parents or relatives so staff had to be competent in paediatric resuscitation. De-brief sessions had been held afterwards to identify areas for improvement. Staff we spoke with could describe this training and what they had learned.

The six emergency nurse practitioners (ENPs) in the ED had received post-registration training to ensure they were competent in their role. ENPs had also attended a bespoke teaching session provided by the clinical lead that had been tailored to their specific learning needs. ENPs trained senior nurses to triage patients. They also held teaching sessions on triaging patients for junior nurses who worked in the corridor during busy periods. However, this was the only form of training some nurses received for accepting ambulance handovers in the corridor.

Newly qualified nurses were placed on a preceptor programme. Preceptorship is a period of structured transition for newly qualified healthcare professionals lasting up to one year, during which support is given by a preceptor who provides supervision, mentoring and support to develop confidence and refine skills. The newly qualified nurses we spoke with felt their preceptorship had met their learning needs and gave examples competencies gained.

Medical staff training was delivered by consultants in weekly teaching sessions, supervision and board rounds. Medical staff spoke positively about the quality of training they received and all felt supported by senior doctors; however, some doctors felt that they were unable to gain experience in treating higher acuity patients, such as major traumas due to services being relocated to other sites. This had been recognised as an issue in the recruitment of medical staff to this ED.

Teaching sessions were held by senior doctors and we also observed junior doctors presenting cases for learning to the medical team. Medical staff were receiving training to administer ultrasound-guided regional blocks for patients with fractured hips, in line with national guidance.

Staff received training to identify, assess and respond to patients with additional needs. The mental health liaison team held communication days to educate ED staff in caring for patients with mental health needs. Liaison leaders had provided training on identifying and managing people with personality disorders and self-harm. Staff had also attended a training session with the trust's substance misuse nurse and a two day course on improving communication with patients with dementia.

Receptionists' awareness and knowledge of 'red flags' for escalating patients upon arrival to the ED was reviewed during PDR meetings with their manager.

Multidisciplinary working

Staff of different specialities worked together as a team to benefit patients; however, specialty doctors did not always arrive to review patients in the ED in a timely way. The trust's professional standards required a doctor to attend the ED within one hour of a patient being referred to their specialty. ED staff used these standards to hold specialty doctors to account if they did not respond to referrals within one hour. There was a system for ED staff to contact the specialty at fifteen-minute intervals after a referral was made. If the specialist had not arrived to the ED within 60 minutes, it was escalated to the consultant responsible. Staff told us that they regularly had to use this escalation procedure. At the time of inspection, 45% of patients received specialty review within one hour.

Medical staff from the ED and other specialties attended joint teaching sessions and meetings called 'grand rounds'. This was an opportunity for doctors to share interesting cases and learning from their respective fields. We saw evidence of ED staff attendance at weekly multi-disciplinary teaching sessions. Staff we spoke with who had attended a grand round felt it improved communication across the hospital.

Multi-disciplinary pathways were in place that incorporated specialties from across the hospital and other sites. For example, the stroke pathway included on-site diagnostic imaging and referral to the stroke services at Worcestershire Royal Hospital for thrombolysis. The pathway for patients requiring emergency surgery involved an on-call surgeon at the Alexandra Hospital attending ED to review the patient before transferring to Worcestershire Royal Hospital for admission.

Healthcare professionals from other services were present in the department and worked with ED staff to co-ordinate care, including discharge of patients with complex needs. The trust had a multi-disciplinary patient flow centre and 'rapid response' team for patients who required additional support after discharge. This included social workers, physiotherapists and occupational therapists.

ED staff worked collaboratively with the trust-wide mental health liaison team for the benefit of patients. From October 2016 to October 2017, 98% of patients were seen within an hour of referral. ED staff skills were developed through joint working procedures. The mental health liaison team had access to further services, such as learning disability, autism and dementia. They referred patients as appropriate based on their assessments.

Staff referred patients to the trust's specialist alcohol liaison nurse, where appropriate. The alcohol liaison nurse's role was to support patients where alcohol had contributed to their attendance in ED. All patients were screened for alcohol problems by a triage nurse and any who scored more than five were offered a referral to the alcohol liaison nurse.

Seven-day services

The ED was open 24-hours per day, seven days per week. Patients could access diagnostic imaging services at all times, in line with the NHS Services Seven Days a Week Priority Clinical Standards.

There was an out of hours GP service located within the ED. Staff could refer patients from 6:30pm to 8am, Monday to Friday and at any time at the weekend.

The mental health liaison service operated from 8am to 9pm, seven days per week. Out of hours, staff accessed the local mental health crisis team for support. The out of hours crisis team was countywide which meant their response to referrals could be delayed.

The frailty assessment unit was opened two weeks prior to inspection and had been operating from 8am to 8pm, Monday to Friday. They were due to commence weekend services at the time of inspection. From November 2017, the frailty assessment unit would be open from 8am to 2pm on Saturday and Sunday.

Patients could be referred to the ambulatory care unit from 7am to 8pm, seven days per week.

Social workers, physiotherapists and occupational therapists were available through the trust's patient flow centre from 9am to 5pm, Monday to Friday. Out of hours, staff could access an on-call team.

Health promotion

Patients we spoke with in the ED had been advised, where appropriate, that exercise, weight loss and reduced alcohol consumption would be beneficial to their recovery. There were leaflets and contact details of support groups and organisations.

Staff received training on palliative care as part of their induction and were able to identify patients who were in the last 12 months of their life. They contacted the trust's end of life team if they felt a patient was in need of extra support. We also saw examples of staff contacting the social workers if they felt a carer needed extra support to cope with patients who had long-term conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Compliance with Mental Capacity Act 2005 (MCA) training was poor.

Information provided by the trust showed compliance with Mental Capacity Act 2005 (MCA) training was 0% for medical staff and 30% for nursing staff in September 2017. This was significantly below the trust target of 90%. The trust acknowledged issues with their data collection for training compliance and told us that the figures they reported may not be accurate due to IT problems. Therefore, we could not be assured that all staff were trained in the decision-making and consent requirements set out in legislation.

During this inspection, nursing staff demonstrated understanding of the principles of MCA by assuming patients had the capacity to make decisions, unless there was evidence to suggest otherwise. If they had concerns regarding a patients' capacity, nursing staff escalated to medical staff or the mental health liaison team. Doctors or mental health nurses would then conduct assessments.

The ED did not carry out audits to monitor the consent process, therefore we could not be assured that they met legal requirements and followed relevant national guidance.

Staff reported that restraint was not used in the department and that physical violence was uncommon. If physical violence occurred, security and/or the police would be contacted.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Patients who were in distress or pain were responded to quickly. However, we observed occasions where patients' privacy and dignity was not respected during their initial clinical assessments.

Patients were initially assessed by a triage nurse in a private room adjacent to the waiting area. After their assessment, notes for non-urgent patients who did not require escalation were kept in the triage room. This meant other staff members had to enter the room to collect the notes. During the inspection, we observed staff frequently entering the triage room during patients' assessments without knocking or apologising for the interruption. This was not respectful of patients' privacy and dignity.

During previous inspections, patients' privacy and dignity was not always maintained due to being cared for in the corridor where there was insufficient space. As a result, the trust was issued with a requirement notice for breaching Regulation 10 HSCA (Regulated Activities) Regulations 2014 Dignity and respect. During this inspection, patients did not spend over ten minutes in the corridor

and their dignity was maintained throughout. When ambulance handovers were conducted in the corridor, staff spoke quietly to maintain patient confidentiality. Patients were then taken to cubicles for further assessment. We were told that during busier periods when an influx of ambulances was expected, a cubicle was reserved to allow patients who were waiting in the corridor to receive their assessments in a private space.

Feedback from patients during this inspection confirmed that staff treated them well and with kindness; however, the ED did not routinely gather feedback so there was limited information from patients for the 12 months prior to this inspection. The department participated in the national Friends and Family Test (FFT), but response rates were below 1% from April to September 2017, compared to the England average of 13%. FFT is a tool that supports people who use NHS services to provide feedback on their experience. It asks people if they would recommend the services they have used. Results from April to September 2017 were variable compared to the national average, but it was difficult to draw conclusions from the data, as the small sample size may not be representative. In August 2017, no patients completed an FFT.

Emotional support

Staff provided emotional support to patients to minimise their distress. Nurses considered patients' emotional wellbeing during care and comfort rounds and at handover. We observed staff taking distressed patients to quiet, private areas and reassuring them when they were anxious. Staff took time to provide toys and play with children if they were scared or upset.

Patients and relatives we spoke to had been signposted to support groups and organisations for emotional and social support. Patients with mental health or dementia diagnoses were referred to the mental health liaison team for further advice.

Staff took relatives to a quiet room to deliver life-changing news.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives we spoke with knew what to expect during their attendance in the department. Staff included patients in decisions regarding their treatment, where possible.

Staff explained things in ways patients understood. We observed medical staff providing patients with forecasts of what would happen next. This was in line with the RCEM Emergency Department Care Best Practice Guideline 2017. Patients were given the opportunity to ask questions and staff took time to answer any queries.

We observed staff preparing a patient for discharge; they discussed the patients' home life to ensure they would not be alone, provided them with a summary of their treatment and advised them of who to contact if they had any concerns.

Patients who received a mental health assessment during their attendance in the ED were asked if the information could be shared with a relative or carer. If a relative or carer was not present at the time, staff contacted them via telephone with consent from the patient.

Patients we spoke with knew who was looking after them while they were in the ED. However, not all staff wore name badges so patients could identify them. This was highlighted during the inspection in November 2016. The nurse in charge wore a badge throughout the inspection so patients and visitors could easily identify them.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

We were told during the inspection in November 2016 that there were plans to set up a frailty team to provide specialist care for frail, older patients. The aim of this team was to minimise unnecessary hospital admission and emergency department (ED) attendance. The team was set up in October 2017 and the frailty assessment unit (FAU) was opened.

The local ambulance service referred appropriate patients directly to the FAU during its opening hours from 8am to 8pm on weekdays, therefore preventing the need for an ED attendance. Out of hours, eligible patients were brought to the ED where they were stabilised overnight and transferred to the FAU in the morning.

We observed this process working well during the inspection. For example, four patients who had arrived to the ED during the night were appropriately referred to the FAU and were transferred by 9am the following morning. This meant the four beds were available for patients who required emergency care. Beds were made available in this manner during each day of this inspection. However, as the FAU had only been open for two weeks at the time of inspection, information to show a sustainable impact on ED was not yet available.

To meet the needs of local people when Worcestershire Royal Hospital ED was full, ambulances were diverted to the Alexandra Hospital ED. There was a protocol for ambulance crews to follow that involved contacting staff at the Alexandra Hospital ED prior to diverting, to establish how many extra ambulances they could accept. This process was followed during our inspection when all patients referred by their GP to Worcestershire Royal Hospital were diverted to the Alexandra Hospital ED. Senior staff had been given prior notice and confirmed that they had capacity to manage the additional patients.

There were no occasions during this inspection where all ambulances were being diverted to this ED; however, staff told us that this had happened over the weekend of our visit. On this occasion, there was no hospital ambulance liaison officer (HALO) on duty which meant the increase in ambulance handovers had to be managed by nursing staff. Senior staff in ED escalated this as a safety concern and the trust responded by contacting the local ambulance service to provide another HALO for that shift. Data showed that there was no significant decline in the EDs performance data during the period of full divert, despite receiving an additional 18 ambulances compared to the previous two days.

Senior staff in the ED were working with the mental health liaison team to improve services for patients who attended the department for mental health reasons. Staff had identified 20 patients who frequently attended the ED for mental health reasons only (no medical condition or injury). The mental health liaison team then developed management plans for each patient that included contact details for their community support workers, with the aim of preventing unnecessary admission to ED. Each patients' management plan was accessible in the ED and also to ambulance crews so that patients could access the most appropriate support without being taken to hospital, where appropriate. The plan was in its infancy as it had only been implemented in the weeks prior to the inspection, so data to show the impact on ED attendances and care for patients with mental health was not yet available. The work was being monitored as part of a Commissioning for Quality and Innovation.

The ED was also working with the primary care services provided in local prisons to deliver co-ordinated care. There were two prisons located near to the hospital; one was a low-secure open prison and another was a high-security prison. People who were detained in prison attended the ED if they required urgent or emergency care. These visits could require a high level of resource from both the ED and the prison service and could be distressing to patients. The ED matron was working with the prison governor and medical team to minimise unnecessary admissions. For example, by sharing processes for patients who may be flight risks to improve safety during visits and promoting the use of the prison's own primary care facilities, where appropriate.

The ED facilities and premises were appropriate for the services delivered. There was adequate seating and space in reception and waiting areas. Televisions in the waiting area displayed the

waiting times of local minor injury units so that people could make an informed choice on where to attend. This information was also available on the trust website. There was a separate children's waiting area with toys and a television. The children's area also had a separate toilet and baby change facility.

The out of hours GP service was co-located in the ED to allow patients to be streamed to primary care, where appropriate. The ED had one allocated slot per hour reserved to refer patients who were assessed as suitable for GP care.

Meeting people's individual needs

There had been some improvement in the department's ability to meet people's individual needs. However, the ED had not improved their compliance with NHS England's Accessible Information Standard to identify, flag, share and meet the information and communication needs of patients with a disability or sensory loss. We saw that the electronic system used to monitor all patients in the department had the capability to do this and was used to flag patients with infection control risks and safeguarding concerns, but was not routinely used to share accessible information or communication needs. Staff also confirmed that this was the case.

During the previous inspections, patients were not always cared for in an environment that met their individual needs; for example, in the corridor. As part of the Section 29A Warning Notice issued in January 2017, the trust was required to take action to significantly improve so that patients were not being routinely cared for in the corridor due to poor flow through the ED. However, when we re-inspected in April 2017, we found patients were still frequently being cared for in the corridor and another Warning Notice was issued.

At this inspection, improvements had been made. We did not observe any patients spending longer than ten minutes in the corridor and their individual needs were met. Reduced crowding also improved the department's ability to provide quiet, calm environments for patients who were living with dementia or learning disability.

The service prioritised distressed patients so they were seen quickly following triage. We observed patients with mental health conditions being seen promptly during this inspection. Where appropriate, staff would refer patients to the mental health liaison team prior to the end of their medical treatment to prevent delays in the patient being discharged.

Staff accessed support and advice from the hospital's dementia lead nurse and learning disability nurse. Flower symbols were displayed in cubicles of patients living with dementia to make it clear to staff that a patient may have additional needs. Staff told us that lead nurses had provided teaching sessions and communication groups to educate them on caring for patients living with dementia or a learning disability.

Staff referred patients to the trust's patient flow centre (PFC) and rapid response team prior to discharge if they had complex health and social care needs. The PFC had access to information on care packages and bed availability across the local health and social care system. They also had links to the local authorities and mental health trust. Staff referred patients to the PFC, where appropriate and we observed social workers attending the department to ensure patients had appropriate care packages in place prior to their discharge.

There was an emergency decision unit (EDU) to allow a short period of observation, investigation or treatment prior to discharge. This was supervised by a consultant on duty.

If patients had additional needs, such as those with a mental health condition, learning disability, autism or dementia, they were placed in EDU or observation cubicles which were near the nursing station. We observed patients with dementia being appropriately placed in observation areas so that nurses had clear visibility of each patient. If a patient was assessed as higher risk using the mental health matrix, the patient was allocated a bed on EDU and the mental health liaison trust were contacted to provide extra supervision.

There was wheelchair access to all parts of the department and the reception desk had a hearing loop for people with hearing impairments. Translators could be accessed via the telephone translation system provided by the hospital. Staff could also access written information in other languages.

Access and flow

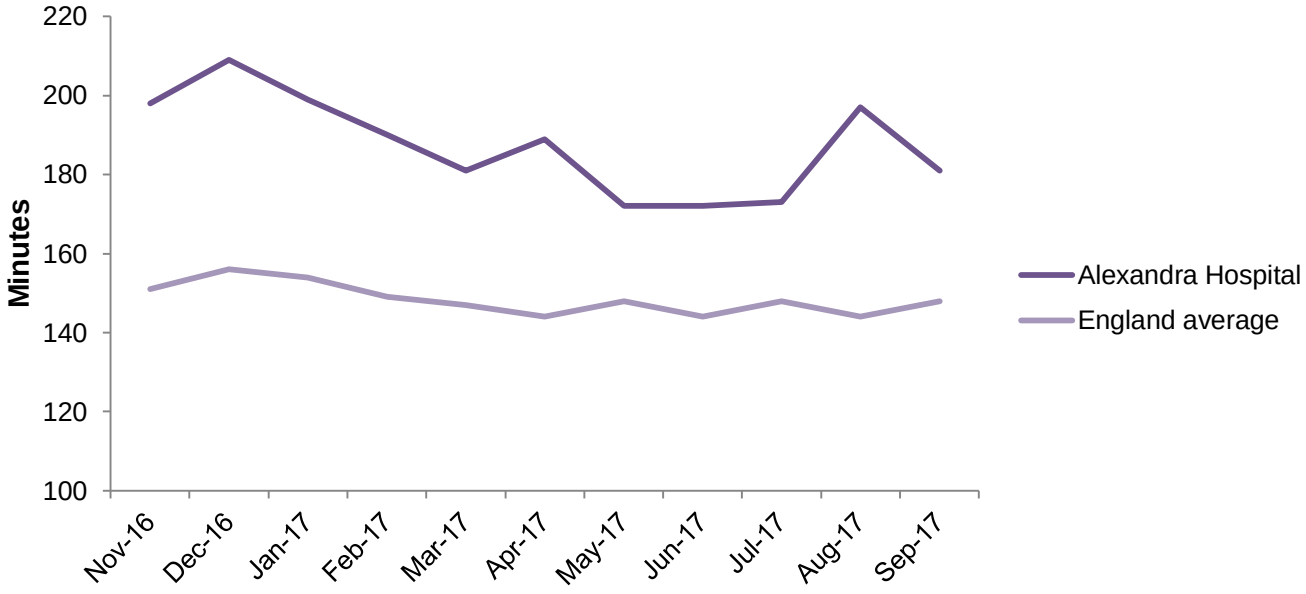
The ED's performance against national access and flow indicators showed some improvement since previous inspections, though not all national standards were met.

Previously, the trust was issued Section 29A Warning Notice due to the lack of effective plans to manage overcrowding in the ED. When we inspected in April 2017, the trust told us that they had developed a new 'full capacity protocol' to manage overcrowding; however, there was no evidence to confirm this was in place. The protocol in use was dated 2015 and actions to reduce crowding were ineffective.

During this inspection, the 2015 full capacity protocol remained in use. An updated version was included in the trust's new capacity management policy; however, this was in draft form and had not been introduced at the time of inspection. We requested information on the amount of times that the hospital had declared full capacity, but the trust did not provide us with this information.

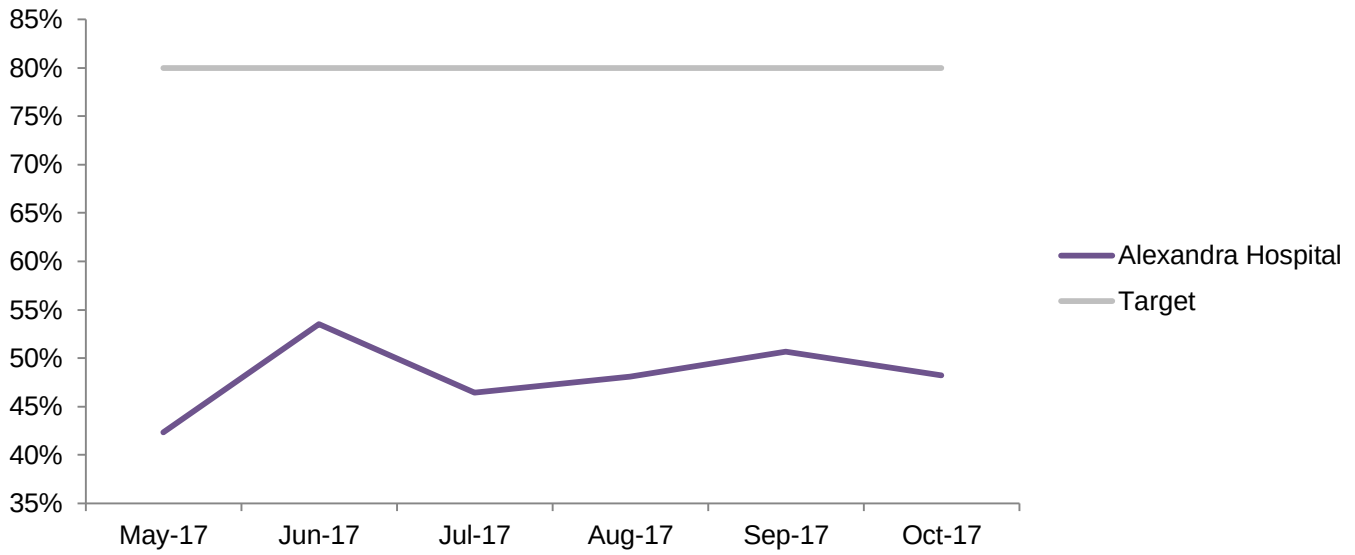
Patients spent longer in this ED than at other trusts in England. The monthly total time spent in ED for all patients was consistently higher than the England average from November 2016 to September 2017. At the time of inspection, patients spent on average 187 minutes in the department.

Median total time spent in ED per patient



Some patients had to wait for specialist doctors to see them before they could be admitted. Despite internal professional standards stating that specialist doctors should respond within one hour of referral some patients waited longer. Patients faced delays due to the timeliness of specialty doctors arriving to ED. From May to October 2017, the ED did not meet the 80% target for the percentage of patients receiving a specialty review within one hour of referral. 48% of patients received a specialty review within one hour of referral. At the time of inspection, performance was at 45%. The average time patients waited for specialty review had improved since the inspection in April 2017 from 93 minutes to 84 minutes, but this still did not meet the recommended timescale.

Percentage of patients receiving specialty review within one hour of referral

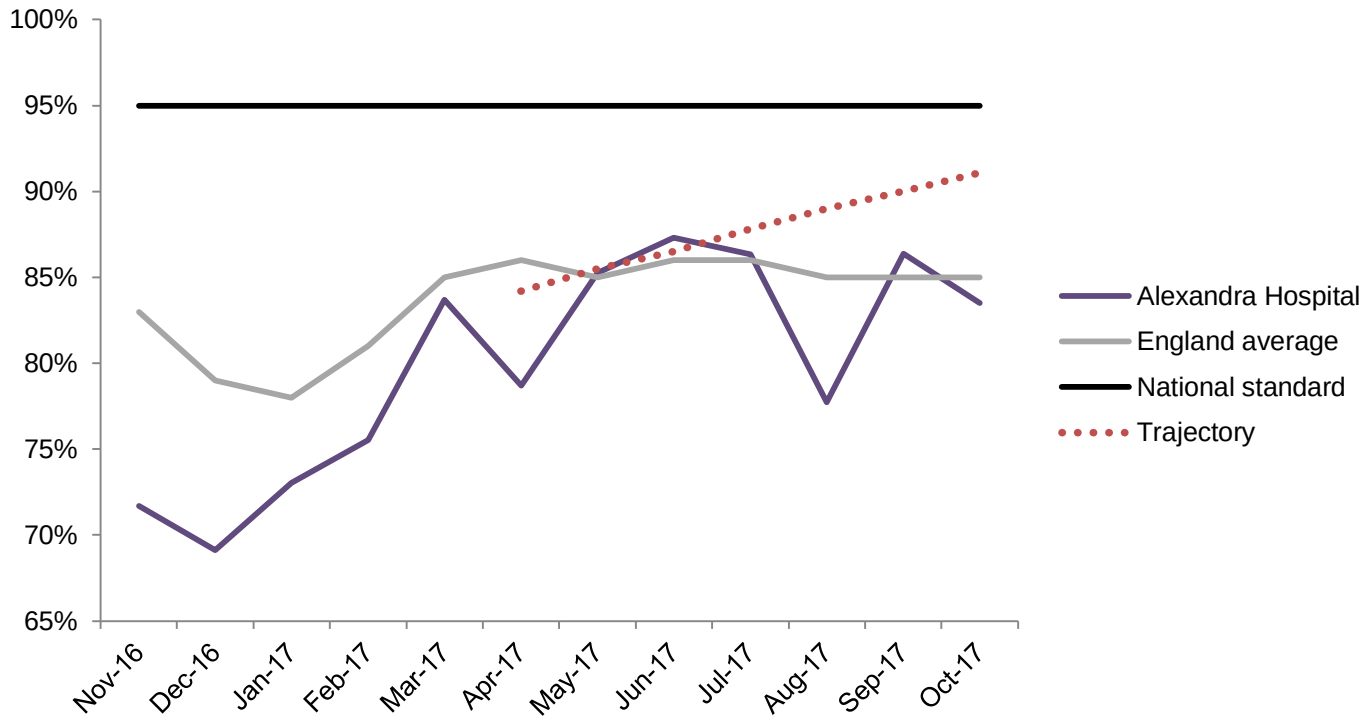


The ED's four-hour target performance showed an overall trend of improvement since the previous inspections, but remained below the national standard and the trust's own trajectory. The Department of Health Emergency Access Standard requires 95% of patients to be admitted, transferred or discharged within four hours of arrival. The ED did not meet the 95% target from November 2016 to October 2017, but performance was similar to the national average for four out of the six months prior to this inspection.

The red line on the graph below shows the trust's trajectory as part of their quality improvement plan. They aimed to meet the 95% target by March 2018, in line with the NHS Five Year Forward View requirement. However, they had not met the trajectory since June 2017. The most recent data showed 84% of patients were admitted, transferred or discharged within four hours of arrival, compared to the trajectory target of 91.1%.

During this inspection, performance varied. For example, on one date of our visit, 92% of patients were admitted, transferred or discharged within four hours; whereas on another date, performance was at 58%. On this occasion, ten of the 24 patients in the department had breached the four hour target.

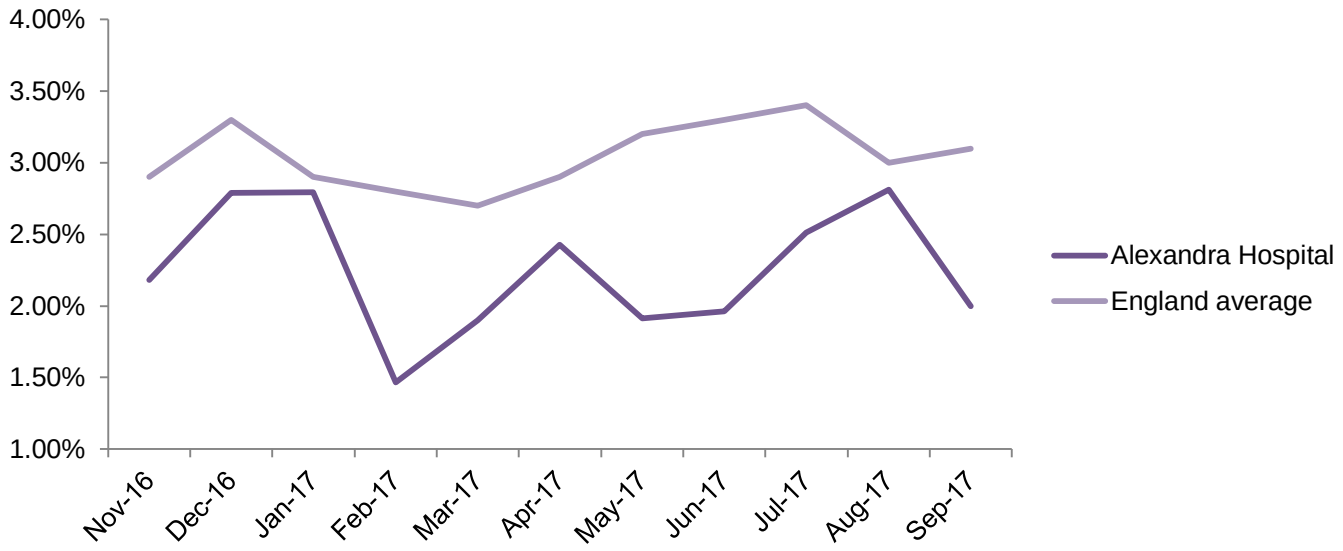
Four-hour target performance



(Source: NHS England - A&E Waiting Times and WAHT Integrated Performance Report September 2017)

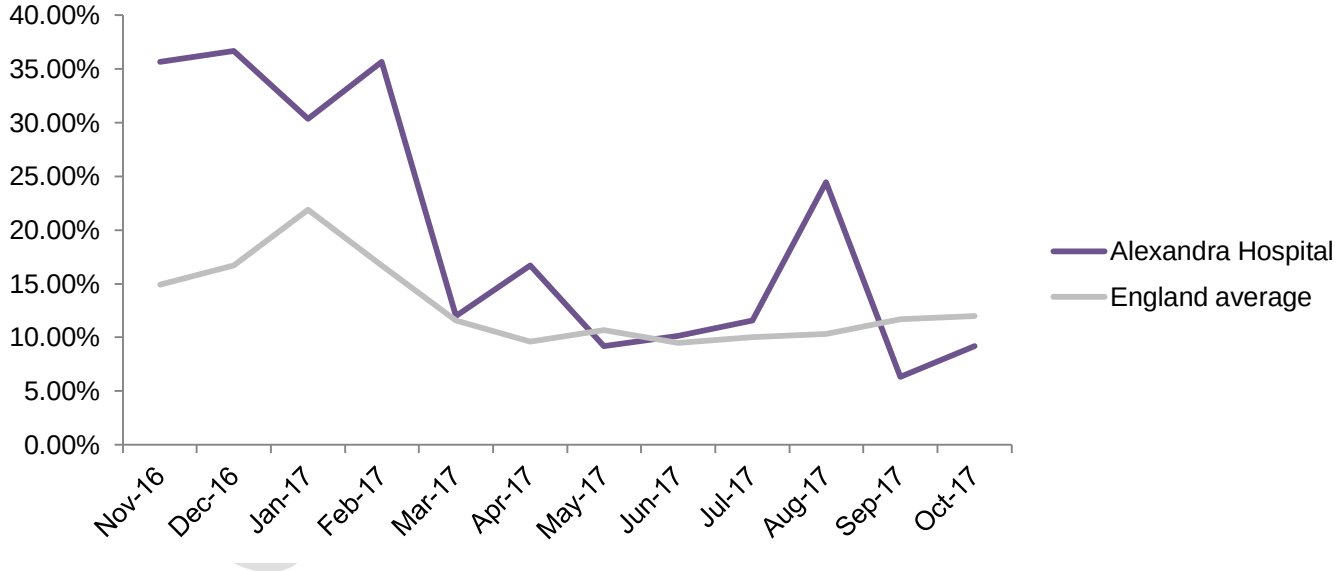
The ED performed better than the England average for the percentage of patients who left the department without being seen from November 2016 to October 2017. 2.2% of patients left this ED without being seen, compared to the England average of 3.2%.

<u>Percentage of patients who left the ED without being seen</u>



Patient flow through the hospital had improved since the inspection in November 2016. This was reflected in the reduced time patients spent waiting for a hospital bed. In November 2016, 36% of patients waited from four to 12 hours from the decision to admit until being admitted. This had improved to 9% in October 2017. Performance showed a trend of improvement over the 12 months prior to this inspection. Since May 2017, performance had generally been in line with the England average, with the exception of August 2017.

Percentage of patients waiting from four to 12 hours from the decision to admit until being admitted



(Source: NHS England - A&E Waiting Times)

From November 2016 to October 2017, no patients waited over 12 hours from the decision to admit until being admitted, with the exception of December 2016 when less than 1% of patients waited over 12 hours.

Patient flow was improved by the ambulatory care and frailty pathways. Previously, significant issues with bed capacity had contributed to poor patient flow and long delays for patients in the ED. In April 2017, we found that this had been slightly improved by the extended opening of the ambulatory emergency centre (AEC). During this inspection, the AEC pathway was embedded and was improving flow through the hospital.

The AEC was for patients who required medical day case care. The pathway allowed patients to receive investigations, senior medical review and treatment in one day; preventing the need for

hospital admission or extended periods in the ED. Suitable patients could be referred directly to AEC by their GP. Patients who self-presented to ED or arrived by ambulance were reviewed for their suitability for care on AEC and could be transferred on, where appropriate.

Senior AEC staff had access to the ED patient monitoring system so they could identify any suitable patients who were waiting. AEC staff also attended ED morning handovers to identify any patients who had arrived overnight who were suitable for transfer. We observed staff utilising the AEC pathway throughout the inspection and suitable patients were identified and transferred promptly. We also observed medical staff discussing patients' suitability for AEC during medical board rounds.

Number of new patients treated in the AEC for the 12 months prior to inspection

Month	Number of patients
November 2016	45
December 2016	96
January 2017	205
February 2017	234
March 2017	239
April 2017	202
May 2017	220
June 2017	226
July 2017	225
August 2017	248
September 2017	215
October 2017	223

During the inspection, flow was also improved by the opening of the frailty assessment unit (FAU). The FAU accepted patients who were assessed as frail but did not require emergency medical or surgical treatment. Access to the FAU was direct via ambulance or GP referral and via transfer from ED.

ED staff attended the hospital bed management daily meetings to discuss bed availability and ED capacity. We observed bed management meetings during the day and out of hours. The ED was declared as busy using the safety matrix and staff from across the hospital were able to resolve issues with flow and bed capacity.

In November 2016, patients experienced delays when there were differences between ED and specialty doctors' opinions regarding which specialty a patient should be referred to. Previously, the trust did not have a process to follow in these situations. During this inspection, the trust had introduced internal professional standards for medical staff to follow. The standards stated that ED consultants had overall authority to refer patients to the specialties they deemed most appropriate. Medical staff from receiving specialties then took over clinical ownership. Not all medical staff were aware of this professional standard; however, we did not observe any occasions where treatment was delayed due to differing senior medical opinions.

Learning from complaints and concerns

Complaints were not responded to in a timely way. From August to October 2017, no complaints had been responded to within 25 working days in line with trust policy.

The complaint management process had recently changed so that senior ED staff had responsibility for complaints relating to their department. Previously, divisional managers were responsible for complaints. This had resulted in delayed responses because divisional managers

were based at Worcestershire Royal Hospital so did not have immediate access to staff or all relevant information.

Senior ED staff were given responsibility for complaints in the weeks prior to this inspection and were working through the backlog. There were ten outstanding complaints in October 2017.

The new process was for senior nurses or consultants to gather information from relevant staff members and contact the complainant to apologise over the telephone, at the earliest stage possible. Staff informed complainants of their initial findings and offered further investigation, if the complainant wished. This would be followed up by a written response. Face-to-face meetings were offered after further investigation, if required.

Complaints were discussed at ED clinical governance meetings. Meeting minutes showed actions to resolve complaints; however, there was little evidence of discussion of learning or how they were shared with staff. Themes from complaints were not reviewed to identify areas for improvement. Staff told us that complaints were sometimes discussed during handover but were unable to describe examples or learning.

Is the service well-led?

Leadership

The emergency department (ED) was previously managed as part of the trust's medicine division. Six weeks prior to this inspection, the medicine division was restructured into two smaller divisions: scheduled care and urgent care. The ED was now managed under the urgent care division, which included urgent and emergency care services only.

The urgent care division was led by a medical director, a director of nursing and a director of operations. The medical director for the division was acting up from their usual role of clinical lead of emergency medicine at Worcestershire Royal Hospital. The divisional director of nursing and director of operations were both substantive appointments and had worked at the trust for over a year.

The aim of the new divisional structure was to increase senior support for the ED. Staff spoke positively about the change and felt that leadership in the ED had improved. Local leaders had welcomed the new, smaller division as they felt more empowered to drive improvement in the department.

The local leadership team for the ED consisted of a clinical lead who was a consultant in emergency medicine and a matron. The clinical lead and matron were highly visible in the department and often worked clinically to maintain their skills and support their staff. The matron worked clinically one day per week and the clinical lead supported staff when the department was busy or they were treating patients with more complex needs. All staff we spoke with felt supported by the local leadership team and felt able to approach their managers with any concerns.

The ED had also identified a lead for mental health care who worked with staff from the mental health liaison service to ensure they met patients' mental health needs.

The new urgent care divisional structure included a general management position which had not been recruited to at the time of inspection. This meant local clinical leaders were responsible for all governance, quality and risk management in the ED. They were supported by divisional managers; however, it was evident from the quality of meeting minutes, information provided and what staff told us on inspection, that local clinical leaders did not always have capacity within their roles to focus on governance and performance to a sufficient level. This meant monitoring the quality and sustainability of the department was not always a priority. Lack of general management was highlighted as a concern during previous inspections.

The stability of trust-wide leadership had improved since the November 2016 inspection. There was a new substantive chief executive and chief nurse. Staff knew who the board members were

and could recognise them from trust-wide communication; however, they were not aware of executives visiting the department in person.

Staff spoke positively about having substantive executives in place and felt that this stability was what the ED needed to promote long-term change. For example, senior staff described having more access to training for their staff since the new chief executive and chief nurse were in role, as they could see the long-term benefits for the department.

Vision and Strategy

There was no documented local strategy for the department. Senior staff told us that their vision for the department was to recruit more medical staff and to become a reputable teaching centre. However, there was little evidence to show that this strategy was in place or that progress was monitored.

A divisional strategy was being developed for the urgent care division at the time of inspection; however, this had not been finalised or implemented.

The trust vision was 'Working together with our partners in health and social care we will provide safe, effective, personalised and integrated care for local people, delivered consistently across all services by skilled and compassionate staff.' The trust also had 'PRIDE' values. This stood for:

- Patients at the centre
- Respect for everyone
- Improve and Innovate
- Dependable
- Empower

Not all staff in the ED were aware of the trust vision and values. Staff we spoke with did not feel the values were meaningful as there had been a number of initiatives implemented in the year prior to the inspection.

Culture

The culture in the ED had improved since previous inspections. In November 2016, there was trust-wide acceptance of long waits for patients and corridor care. At this inspection, the culture was now focused on teamwork and putting patients first.

Relationships amongst staff in the department were cooperative, supportive and appreciative. Nursing staff and medical staff shared responsibility and worked together for the benefit of patients. Nurses told us that medical staff often supported them with care duties when the department was busy and medical staff reported that the nursing team always provided high-quality care for patients. Local leaders in the ED reported feeling more empowered to drive improvements, particularly with the new divisional structure and separate leadership for urgent and emergency care.

Staff felt supported, respected and valued. Staff now said they felt proud to work for the trust and the ED. Three members of temporary staff, including students, had accepted substantive roles in the department. They told us that the teamwork and support they had received during their agency work/placement was a key factor in their decision to apply for a substantive post. All staff we spoke with felt part of the ED team, including non-clinical and agency staff.

Staff gave examples of when the matron and clinical lead had supported them through times of personal difficulty, such as allowing flexible working to meet their needs.

Patients' wellbeing was monitored on an ongoing basis. Records we reviewed included details on their mental health, emotional wellbeing and social situation. We observed this was discussed at nursing handovers and during medical rounds.

Since the appointment of the substantive chief executive, the clinical lead and matron were focussing training and development in the department. They were committed to developing their own staff to gain greater experience, competence and promotion. For example, one nurse was being supported to undertake a master's degree to become qualified as an ENP at the time of inspection.

The trust had recently implemented cultural improvement programme, '4Ward'. The 4Ward programme introduced a set of signature behaviours that the trust intended to become part of everyday practice. The signature behaviours were:

- Do what we say we will do
- No delay, every day
- We listen, we learn, we lead
- Work together, celebrate together

In the ED, staff we spoke with were aware of the programme. Some staff members knew the signature behaviours, but others did not feel engaged with the initiative as they had seen a number of programmes implemented over the previous years. They felt that this was one of many and expected the signature behaviours to change again.

The trust had recently appointed a Freedom to Speak Up Guardian. However, staff in the ED did not know how to contact the Freedom to Speak Up Guardian or the purpose of this role.

Governance

The quality of clinical governance remained a concern at this inspection. Some improvements had been made; for example, a consultant had been appointed as clinical governance lead and monthly governance meetings had been taking place since July 2017. However, attendance at these meetings varied and was often the clinical lead, governance lead and matron only. Also, as there were only two substantive consultants in the department, we were not assured that the clinical leaders had sufficient capacity to fulfil governance duties, in addition to clinical work requirements.

The clinical governance meeting agenda included key areas, such as the risk register and audits, but did not include serious incidents. We were not assured that information from meetings was effectively disseminated to staff. We were told that governance information was disseminated via email and at staff meetings; however, staff meetings were not always minuted and staff we spoke with were not aware of recent communication. We therefore could not be assured that the governance arrangements supported the delivery of good quality patient care. This was highlighted as an issue during the inspections in November 2016 and April 2017.

Senior nursing meetings minutes provided included some discussion around clinical governance including risk, plus complaints and staff training.

There were no joint governance arrangements between the ED and the out of hours GP service that was located within the department. There were no formal meetings to review the effectiveness of the streaming process. We spoke with staff from the out of hours GP service, which was provided by another organisation and were told that there was little communication between the services. For example, on average one patient per night was inappropriately referred to the GP from the ED, but this was not being reviewed or monitored.

The trust had recognised there were issues with the governance structure and arrangements in the ED. In the integrated performance report from September 2017, a decision was made for an

executive director to support the urgent care division to improve their governance and performance management.

The ED had appointed a sepsis lead nurse. The sepsis lead met with the trust-wide sepsis management group each week to monitor compliance with sepsis screening, use of the Sepsis 6 bundle and discuss areas for improvement. Information from these meetings had been shared with the ED team and all staff we spoke with were aware of audits and improvements.

Managing risks, issues and performance

In the Section 29A Warning Notice issued in January 2017, risk management in the ED was an area where the trust was required to make significant improvement. The issues included lack of effective oversight of incidents and not all risks being identified and managed on the departmental or divisional risk registers. When we re-inspected in April 2017, little improvement had been made. We were not assured that risks, issues and performance were effectively managed in the ED and a further Section 29A Warning Notice was issued. This particularly related to the lack of effective plan to manage crowding and patients being cared for in the corridor.

During this inspection, there had been some areas of improvement, but most of the issues remained.

Risk management processes remained an area of concern. The ED did not have its own risk register. Some departmental risks were reported on the urgent care divisional risk register; however, there were only four risks related to this ED. This included delays in mental health assessment at night and medical staffing levels. The risk register summary that was initially provided included a description of the risk, the effect and the impact but risks were not graded according to severity or likelihood and there were no mitigating actions or control measures recorded. It was therefore unclear how risks to patients were being managed and reviewed at departmental level. In response to us querying this, the trust provided a further document which contained more detail. This document showed risks relating to ED at the Worcestershire Royal Hospital were described within Datix risk management system. The fields within the Datix risk management system included risk rating according to consequence and likelihood which is recorded at first assessment, subsequent assessment is detailed within the body of the risk. All risks include a review date, controls, gaps in controls, assurances, gaps in assurances, and subsequent mitigating actions with action review dates. However, it was unclear how staff used both documents effectively to manage and mitigate risks.

It was unclear when the risks were last reviewed or updated from the risk register summary that was initially provided, included a description of the risk, the effect and the impact but risks were not graded according to severity. For example, the document provided by the trust was dated 3 November 2017 and included the risk of not having an appropriate room for mental health assessments that met national safety standards. However, this risk was no longer present in the department as an allocated mental health assessment room had been safety approved in October 2017. Other risks referred to findings from audits conducted in February 2016 with plans to re-audit in March 2016. There was no evidence to show whether the re-audits took place or what the impact was on this risk.

Clinical governance meeting minutes from September 2017 included a brief discussion on the risk register. However, this did not include any discussion around review or actions to mitigate the risks. We therefore could not be assured that risks were being reviewed or managed appropriately at local level to keep patients safe.

There were some risks relating to ED reported on the trust-wide corporate risk register. This included breaching the four-hour target, staffing levels and crowding in the ED. Senior ED staff described how they escalated risks to the corporate risk register via divisional management.

There was lack of performance monitoring and review at local level. This remained an issue since the inspection in November 2016. Performance was discussed at divisional management

meetings; however, minutes lacked detail or actions to improve. Also, recent changes to divisional structure meant performance management arrangements were not finalised at the time of inspection.

From July to August 2017, performance was reviewed by the medicine division using a 'performance factsheet'. The performance factsheet included a brief overview of the trust's EDs but did not include any discussion around how performance could be improved. These meetings did not involve staff from the ED and it was unclear how information was disseminated. In September 2017 when the new urgent care division was introduced, these meetings no longer took place.

From September 2017, ED performance was to be reviewed as part of trust-wide capacity management meetings and weekly departmental meetings. However, the weekly dashboard from these meetings did not include specific performance data for this ED; the information was trust-wide or from Worcestershire Royal Hospital only. Divisional performance reviews for the urgent care division had not been implemented at the time of this inspection in November 2017. We therefore could not be assured that ED performance was being monitored or managed effectively to improve care and treatment for patients.

There was a safety and quality improvement dashboard, known as the safety and quality information dashboard (SQuID), in use in the department. The SQuID displayed departmental information, such as the number of incidents, complaints, NEWS audit results, sepsis audit results, falls and use of the safer staffing tool. Senior staff told us that this was discussed during staff meetings; however, as meetings were not minuted, we were unable to confirm this. This information was discussed at divisional level, but there was no evidence to show how the information was used to improve service delivery.

There had been an improvement in internal audit systems. In addition to the newly implemented clinical audit programme, there was also a systematic programme of internal audit to monitor nursing and care quality. This had been implemented in July 2017. Senior nurses conducted daily audits of patient records, including sepsis management. There were also weekly observational audits of the department to monitor compliance with the below questions:

Q1	Are all staff in correct uniform?
Q2	Is the medical notes trolley locked or supervised?
Q3	Is the nurse in charge (NIC) wearing the NIC badge?
Q4	Has a board round taken place?
Q5	Has the resuscitation equipment been checked in the previous 24 hours?
Q6	Are all staff bare below the elbows?
Q7	Has a nursing documentation pack been started?
Q8	Has the patient got a name band and is it the right colour?
Q9	Has the care and comfort round documentation been completed?
Q10	Have the NEWS been correctly calculated?
Q11	If the patient score is above 5, have they had a sepsis screen?
Q12	If required, have they been escalated to the NIC?
Q13	Has a skin map been completed?
Q14	If required, has action been taken to protect the patient?
Q15	Does the patient have a cannula?
Q16	Has the peripheral vascular disease (PVD) documentation been completed?

Weekly results from July 2017 to October 2017 show compliance was 100% in most questions each week. However, one area where compliance was repeatedly below 90% was sepsis screening for patients with NEWS over five. During this inspection, results had been reported to the trust-wide sepsis group and actions to improve had been communicated to nursing staff.

Managing information

Information on ED performance was not readily accessible within the department. A central team stored data on key performance indicators and reported information to divisional management. ED staff had to send an email to request the information from the trust's central information hub and wait for a response. On the occasions we observed, this process took a number of hours.

Senior ED staff were unable to provide us with evidence of regular performance monitoring that had taken place at departmental level. We were therefore not assured that information on performance was cascaded to the department or being used to monitor improvements at a local level.

We could not be assured that performance, quality and sustainability were discussed with staff at departmental meetings, as meetings were not routinely minuted. Print outs of information, such as recent incidents were available in the staff room, but this did not ensure staff were kept up to date as not all staff we spoke with were aware of recent communication or changes.

Data across the trust was not always managed effectively to ensure it was accurate and reliable. For example, the trust had issues with monitoring staff training compliance. Senior nursing staff in ED were keeping local records as a result.

Engagement

People's views and experiences were not routinely gathered or acted upon. There was very little patient engagement and we saw no evidence of patient feedback used to improve the service. The Friends and Family Test (FFT) response rates were consistently below 1% from November 2016 to October 2017. Improving FFT results for the ED was part of a trust-wide quality improvement plan; however, no actions to improve had been taken in the department. Staff did not actively encourage patients or visitors to fill in FFT feedback forms. This was a potential missed opportunity for learning and improving patient care.

Part of the executive directors' weekly departmental checks included checking if FFT results were displayed. A recommendation from the audit for the week commencing 29 September 2017 was to display FFT results. This recommendation had not been actioned during our inspection and FFT results were not visible for patients and visitors.

We were told by the trust that members of the Patient Public Forum were involved in conducting reviews of care in the ED corridor. However, staff were unaware of these reviews and could not provide information on results or actions to improve.

Prior to attending, the public could access live waiting times for the ED and neighbouring minor injuries units via the trust website. This meant people had a more informed choice when deciding which department to attend.

During previous inspections, staff engagement was poor and those we spoke with felt unable to drive improvements. There was lack of communication from divisional managers and staff did not feel supported through the difficulties faced. During this inspection, we found that, although divisional managers were still based at Worcestershire Royal Hospital and only visited the Alexandra Hospital ED once or twice per week, local senior staff reported feeling more engaged and able to make changes. This was due to the divisional restructure.

Learning, continuous improvement and innovation

The trust had a quality improvement plan in place to address areas of concern identified in the Section 29A Warning Notices, requirement notices and previous inspections. In the ED, not all issues had been addressed.

Areas of concern highlighted in the Section 29A Warning Notice that had not improved:

- Learning from incidents was not always implemented, disseminated or reviewed.
- Although mortality and morbidity meetings had commenced, the quality of review remained poor. Minutes we reviewed were incomplete and did not identify areas for improvement. We therefore could not be assured that the ED was learning from deaths.
- Safeguarding training compliance remained below 90%; particularly medical staff compliance with safeguarding vulnerable adults level 2, which was 0% in November 2017.
- The level of consultant presence in the ED had not improved to meet RCEM recommendation of 16 hours per day, seven days per week.
- The trust remained unable to provide accurate training rates for all staff in the ED.
- Governance structures did not ensure information from departmental clinical governance meetings was shared with staff to support the delivery of good quality care.
- There was lack of performance monitoring and review at local level. Performance was discussed at divisional management meetings; however, minutes provided by the trust lacked detail or actions to improve.
- We were not assured that all data provided by the trust was accurate or reliable.
- There was lack of a comprehensive plan to address crowding in the department when the hospital was at full capacity. The full capacity protocol in use was dated 2015 and the new version remained in draft form.
- There was no departmental risk register. The urgent care divisional risk register was not graded and did not include mitigating actions or control measures.

Areas of concern where there had been some improvement:

- The ambulatory care and frailty pathways were in place to address capacity issues in ED and across the hospital. Improved flow was reflected in the reduced delays for patients waiting to be admitted after a decision to admit was made. The frailty assessment unit was recently opened and we observed a positive impact on flow through ED during this inspection.
- From November 2017, effective recruitment meant the ED would be in line with standards set by the Royal College of Nursing and the Royal College of Paediatrics and Child Health for paediatric EDs of their size. However, at the time of inspection, they were not meeting national guidance as only one registered children's nurse was employed.
- Five newly recruited nurses had commenced in role and a further three had confirmed start dates. This allowed the department to maintain safer staffing levels than during previous inspections.
- There was a significant reduction in the number of patients who were cared for in the corridor during this inspection. We were told there had been a sustained reduction in the use of the corridor; however, the trust were unable to provide data to confirm this.
- Senior ED staff were now collecting and monitoring their staff mandatory training compliance as trust-wide data issues were ongoing.
- The system for recording medicines given by ambulance crews was embedded and ambulance records were incorporated into patients' ED notes.
- Nursing staff appraisal rates were now being monitored.

Work was ongoing to improve mental health care for patients in the department; in particular, those who were assessed as requiring alcohol detox. The alcohol liaison nurse had recently completed a six-month pilot of offering alcohol detox therapy in outpatient clinics. Patients who presented to the ED and were assessed as appropriate for the programme were offered follow-up appointments, to prevent unnecessary hospital admissions. The pilot was found to have saved 84 bed days for 15 patients and was to be continued.

Senior staff in the ED told us that they planned to pilot a rapid assessment and treatment (RAT) model in 2018. Rapid assessment and treatment models are recognised by the Royal College of Emergency Medicine and involve a senior clinician seeing and treating patients as soon as possible after their arrival. Rapid access to a senior clinician means decisions can be made earlier in the patient's attendance and therefore promote timely access to treatment. A senior nurse had been recruited and we were told that the intention was to pilot the RAT model using this nurse as they were suitably trained and had experience in RAT systems. However, there was no documented evidence of this plan.