Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Victoria Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Urgent and emergency services	

Summary of findings

Letter from the Chief Inspector of Hospitals

Blackpool Teaching Hospitals NHS Foundation Trust was established in December 2007 and serves a population of around 440,000 residents and around 11 million tourists and transient visitors seasonally. The trust has an acute hospital, Blackpool Victoria Hospital, two community hospitals, three elderly rehabilitation hospitals, a national eye treatment centre and a child development centre. The trust employs over 7000 staff, has an annual turnover of over £410 million and has 830 beds across all sites. The trust sees over 250,000 outpatients, 56,000 day cases and 91,000 emergency admissions annually.

This was an unannounced, focused inspection to review the safety of the emergency department as part of a focussed winter inspection programme. It took place between 1pm and 10pm on Monday 7 January 2019.

We did not inspect the whole core service therefore there are no ratings associated with this inspection. Our key findings were:

Our key findings were:

- The emergency department (ED) did not have space and capacity to cope with the number of patients and their relatives who presented there. We observed patients sitting on the floor of the waiting room and trolleys, beds and equipment blocking corridors and exit routes, which limited the standard of care.
- The paediatric ED was not compliant with staffing levels set by the Royal College of Paediatrics and Child Health (RCPCH).
- There were significant delays in most aspects of the service, including triage delays of over three hours. We found delays in transferring patients awaiting a mental health bed of over 17 hours whilst awaiting review by the mental health provider, which was separate to the trust.
- Flow to the rest of the hospital did not meet demand and there was very limited input from acute medical physicians. This reflected our discussions with nine members of medical staff, during which they said there was a culture in which specialty teams did not work well together for the improvement of patient experience.
- Patients were accommodated in corridors for extensive periods during our inspection. This included elderly patients and those with severe dementia and staff did not always meet their individual needs. Use of corridors was part of the trust's surge plans during periods of exceptional demand.
- Overnight medical cover was restricted to one doctor with higher specialist training at grade ST4 (specialist trainee) with one or two doctors at basic specialty trainee level (ST3). This caused lengthy delays to assessment and all staff we spoke with told us it resulted in additional pressure.
- Provision for mental health patients was lacking and the trust had limited influence to improve the service provided to their patients.
- We saw isolated examples of very poor, unkind care in the acute medical unit during a violent incident.
- Staff described increasing levels of threatening behaviour, aggression and violence towards them from patients and relatives.
- There were senior decision-makers present in the resuscitation area and in the rapid assessment and treatment (RAT) area who managed patients appropriately.
- There was effective clinical collaboration between the consultant in charge and the nurse in charge and it was notable that staff systematically did their best in challenging circumstances.
- Staff demonstrated resilience and compassion when trying to help patients who had waited significant periods of time in the ED for a mental health review. This included when they faced aggression and verbal abuse.
- The patient and staff safety team had wide-ranging responsibilities and provided considerable support, including in safeguarding and child protection circumstances.

Summary of findings

- The trust had a range of developing strategies to improve access, flow and capacity. These were in the early stages of development at the time of our inspection and we saw limited impact of them to date. Staff provided evidence the improvement works had resulted in faster treatment and an improved experience for some patients, particularly those who arrived by ambulance.

We told the trust they must:

- Further improve performance in the national 15-minute triage recommendation.
- Improve standards of care, including triage, time to assessment and time to mental health review, for patients with mental health needs.
- Ensure the paediatric ED is compliant with RCPCH staffing level standards.
- Review the availability of medical staffing in ED overnight.

In addition, the trust should:

- Improve governance processes and clinical governance oversight of the number of refused referrals to the urgent care centre through the streaming process.
- Improve the management of the waiting area in the main ED to ensure patients who are vulnerable are not put at risk by patients who pose a threat to their safety.
- Continue to work in partnership with the mental health provider and other providers to review the tools used to assess and improve the mental health pathway.
- Ensure staff working in the acute medical unit have the training and supervision to provide a caring and compassionate service.
- Effectively manage crowding in all areas of the ED.
- Review the flow of patients through the paediatric ED to reduce the time children spend waiting with adults.
- Ensure there is a clear, defined and ratified standard operating procedure for the ambulatory emergency care unit and ensure that staff understand this and adhere to it.
- Ensure patients have access to food and fluids during their time in the department.

There were also areas of outstanding practice:

- Senior ED staff had introduced more consistent support for staff following an incident, including a 'support basket' with items to encourage staff to come together and debrief for 15 minutes. Staff spoke highly of this initiative and said it helped them to focus again on patient care after a stressful period or incident.
- The trust had facilitated the implementation of a 'synergy car' service for patients who called 999 with urgent mental health needs. The service was staffed by a police officer, mental health crisis worker and a paramedic. In its first week of operation the synergy service had prevented seven unnecessary ED attendances and 17 attendances for patients detained under section 136 of the Mental Health Act.
- Although ED nurses lacked formal training in the management of mental health conditions, they demonstrated exceptional resilience and compassion when faced with patients who were clearly deteriorating. This included an ED nurse who remained kind and compassionate despite a patient screaming in their face after being in the department for 17 hours.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		We carried out an unannounced focussed inspection of the emergency department as part of a programme to assess safety during the winter period. We did not inspect any other core services or other locations provided by Blackpool Teaching Hospitals NHS Foundation Trust. We visited the acute medical unit and the emergency ambulatory care unit. An urgent care centre and a mental health decision unit were provided by other organisations. We visited these to better understand the patient pathway and how the trust maintained oversight of patient care. We inspected using our focussed methodology, which did not look at all key lines of enquiry. We did not rate this service at this inspection.

Blackpool Victoria Hospital

Detailed findings

Services we looked at
Urgent and emergency services.

Detailed findings

Contents

Background to Blackpool Victoria Hospital

Blackpool Victoria Hospital is an acute hospital that is part of a number of services operated by Blackpool Teaching Hospitals NHS Foundation Trust. The hospital serves a local population of around 330,000 with a transient summer population of over 11 million people.

Blackpool has the 10th most deprived population in England. Men have the lowest life expectancy in England and Wales and life expectancy is five years lower for men and three years lower for women compared with the national average. The prevalence of HIV infection is almost double the national average per 1000 people and this is reflected in the proactive approach to testing every patient for HIV in the acute medical unit.

From August 2017 to July 2018 the emergency department saw 77,007 adult attendances and 14,319 child attendances. Both figures reflected a reduction in attendance of around 10%. During this period 46% of patients arrived by ambulance and the admission rate was 37%, which was an increase of 7% from the previous year. In October 2018, 7% of patients left the department without being seen and 9% of patients reattended within seven days of discharge.

Streaming and reception services are provided by another organisation under contract from a Clinical Commissioning Group, which means patients may be directed to an urgent care centre, which is operate by the other organisation. Our report considers care and treatment once patients are established as the responsibility of the trust.

Our inspection team

The team included a CQC inspector, a national professional advisor, a clinical fellow and a specialist advisor.

The inspection was overseen by Bernadette Hanney, Head of Hospital Inspection.

How we carried out this inspection

Before our inspection we reviewed the data we held about the trust's national performance, including against Department of Health and Social Care four-hour wait targets. We also reviewed the latest data from the trust on mortality, admission and re-attendance rates.

We carried out an unannounced, focussed inspection on 7 January 2019.

Detailed findings

During this inspection we visited all areas of the emergency department including the reception and waiting areas for adults and children, majors and resuscitation areas and the rapid assessment and treatment area.

We reviewed 18 patient records to identify the amount of time people spent in the department and to review patient care. We reviewed the records of a further eight patients being treated during our inspection.

We spoke with 17 members of staff representing a range of different grades and roles including staff who did not work for the trust but who provided services to their patients. We attended a bed meeting to observe how the senior team coordinated capacity and demand. We also spoke with six patients and relatives and we observed care and treatment being delivered.

Facts and data about Blackpool Victoria Hospital

The emergency department (ED) has a four-bedded resuscitation bay, a majors area with 13 bed bays, five cubicles in a rapid assessment treatment area and five side rooms in a clinical area designated as 'assessment B'. The resuscitation bay includes one space for paediatric resuscitation and assessment B includes a side room reserved for mental health patients and a side room that can accommodate up to four seated ambulatory patients. The mental health room is accredited by the Royal College of Psychiatrists psychiatric liaison accreditation network (PLAN). There is a separate paediatrics ED with four cubicles. Both areas have a room for triage and adult ED has a triage bay with space for two trollies for patients arriving by ambulance.

The ED is not a designated major trauma centre and patients are stabilised before being transferred to other hospitals. The hospital is the regional cardiothoracic centre, which means any patients with penetrating trauma to the chest are treated there.

The ambulatory emergency care unit has two bed bays and two assessment rooms with capacity for 10 patients. The acute medical unit has 38 beds in total across six side rooms and two bays of eight beds each, segregated by gender.

Urgent and emergency services

Safe	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The emergency department provides care and treatment to around 77,000 patients a year including for medical and surgical emergencies and trauma care. There is a separate paediatric waiting room and treatment area. Patients with minor illnesses and minor injuries are streamed to a primary care urgent care centre. This is staffed by GPs and based in the same building as the emergency department and is operated by a different provider. We visited the urgent care centre and talked to staff as part of our checks on streaming and flow but did not include it in our inspection.

A mental health decision unit that can accommodate up to four patients for up to 23 hours is based next to the emergency department. This service is provided a different provider and was not part of this inspection. However, we visited the unit and spoke with staff as part of our review of access and flow for patients presenting to the emergency department.

The acute medical unit provides short-term inpatient care to patients from multiple medical specialties. We included this unit in our inspection as part our standard urgent and emergency care reporting framework and because we wanted to check how the emergency department and acute medical unit worked together to improve access and flow.

We visited all areas of the emergency department including the reception and waiting areas for adults and children, majors and resuscitation areas and the rapid assessment team area.

We reviewed 18 patient records to identify the amount of time people spent in the department and to review patient care. We reviewed the records of a further eight patients being treated during our inspection. We spoke with 17 members of staff representing a range of different grades and roles including staff who did not work for the trust but who provided services to their patients. We attended a bed meeting to observe how the senior team coordinated capacity and demand. We also spoke with six patients and relatives and we observed care and treatment being delivered.

Urgent and emergency services

Summary of findings

We did not inspect the whole core service therefore there are no ratings associated with this inspection.

Our key findings were as follows:

- The emergency department did not have space to cope with the number of patients and their relatives who presented there. We observed patients sitting on the floor of the waiting room and trollies, beds and equipment blocking corridors and exit routes, which limited the standard of care.
- The ED team had limited oversight of the streaming service, which was provided by another organisartion. Children were streamed with adults and there were no safeguards in place for children at risk of deterioration who may be inappropriately redirected to the urgent care centre. The trust did not have appropriate risk management strategies in place to address this.
- The paediatric ED was not compliant with staffing levels set by the Royal College of Paediatrics and Child Health.
- There were significant delays in most aspects of the service, including triage delays of over three hours. We found delays in transferring patients awaiting a mental health bed of over 17 hours whilst awaiting review by the mental health provider, which was separate to the trust.
- Flow to the rest of the hospital did not meet demand and there was very limited input from acute medical physicians. This reflected our discussions with nine members of medical staff, during which they said there was a culture in which specialty teams did not work well together for the improvement of patient experience.
- Patients were accommodated in corridors for extensive periods during our inspection. This included elderly patients and those with severe dementia and staff did not always meet their individual needs. Use of corridors was part of the trust's surge plans during periods of exceptional demand.
- Overnight medical cover was restricted to one doctor with higher specialist training at grade ST4 (specialist trainee) with one or two doctors at basic specialty trainee level (ST3). This caused lengthy delays to assessment and all staff we spoke with told us it resulted in additional pressure.
- Provision for mental health patients was lacking and the trust had limited influence to improve the service provided to their patients. Another organisation provided mental health services but the ED team had limited oversight of this and were unable to drive service improvements.
- We saw an example of very poor, unkind examples of care in the acute medical unit during a violent incident.
- Staff described increasing levels of threatening behaviour, aggression and violence towards them from patients and relatives.

However:

- There were senior decision-makers present in the resuscitation area and in the rapid assessment and treatment (RAT) area who managing patients appropriately.
- There was effective clinical collaboration between the consultant in charge and the nurse in charge and it was notable that staff were trying to do their best in challenging circumstances.
- Staff demonstrated exceptional resilience and compassion when trying to help patients who had waited significant periods of time in the ED for a mental health review. This included when they faced aggression and verbal abuse.
- The patient and staff safety team had wide-ranging responsibilities and provided considerable support, including in safeguarding and child protection circumstances.
- The trust had a range of developing strategies to improve access, flow and capacity. These were in the early stages of development at the time of our inspection and we saw limited impact of them to date. Staff provided evidence the improvement works had resulted in faster treatment and an improved experience for some patients, particularly those who arrived by ambulance.

Urgent and emergency services

Are urgent and emergency services safe?

Environment and equipment

The service had suitable equipment which was easy to access and ready for use.

The emergency department (ED) had a four-bedded resuscitation (resus) bay, 13 majors cubicles and five patient bays each in a rapid assessment and treatment (RAT) area and a clinical area named 'assessment B'. One bay in assessment B was a designated mental health room and one bay could accommodate up to four seated patients who required ambulatory care. The mental health room was accredited by the Royal College of Psychiatrists psychiatric liaison accreditation network (PLAN). A separate paediatric ED with four clinical bays and a waiting area was located adjacent to the main ED. Each ED had a designated triage room and there were two triage bays in adult ED for patients who arrived by ambulance.

The layout and capacity of the ED was not suitable for the number of patients in the department. During our inspection the waiting room for the ED was overcrowded for most of the day, with patients sitting on the floor and tempers clearly fraying as a result. For example, we observed several arguments break out and parents remove children from the waiting room to wait in the adjacent corridor, which was quieter. Patients were cared for in the corridor between the RAT area and majors, which restricted access for wheelchairs and other equipment. Part of the majors area was used to store boxes of consumables and clinical equipment. The overcrowded nature of the area and number of patients accommodated on trollies presented a risk in the event of an evacuation.

The resus area was well-equipped but cramped with only four small cubicles, one of which was designated for paediatric emergencies. During our inspection the nurse in charge closed one of the resus bays due to a water leak from the ceiling. There was a fast response from the on-call facilities team and ED staff managed the loss of capacity appropriately.

It was common practice for the ED team to provide care for patients on trolleys in a corridor due to a lack of space as part of surge plans during times of exceptional demand. Although this helped to reduce waiting times and keep some momentum in patient flow, it presented challenges to care. There was not enough space to use privacy screens, which compromised the dignity of patients undergoing examination in the corridor. This also meant there was no space for private discussions. Throughout our inspection staff struggled to organise the space logistically and safely due to the volume of patients and the amount of equipment present. We saw nurses completely block exit routes and corridors whilst trying to manoeuvre patients on trolleys and beds. This was always temporary whilst they organised the environment but it presented an elevated risk.

All the staff we spoke with identified the lack of clinical space as a significant concern. The ambulance triage area became overcrowded with relatives waiting for patients in RAT and in the triage area. This created further challenges for staff and the area was difficult to manage. The security system that was designed to restrict access to clinical areas to authorised persons had been disengaged for the adult ED. Staff told us this was because of crowding in the area and the number of people who needed repeated access. However, there was not a continual security presence in this area and we saw staff were not able to keep track of who was in the area and why.

There was sufficient equipment such as adult, infant and paediatric pulse oximeters, blood pressure machines, thermometers, oxygen and suction for the number of patients requiring these. Patients in cubicles had access to call bells to call for staff if required. It was common practice for patients to be cared for in a corridor due to a lack of clinical space. The department had implemented two mobile call bells for patients in the corridor so they could call for assistance when needed. However, there were up to 14 patients cared for in corridors, which meant most of them did not have a means to call for immediate help.

Only two majors cubicles had facilities for cardiac or advanced clinical monitoring. This meant patients were kept in the resus for extended periods of time.

Staff had access to sepsis toolkits. These were locked mobile trollies which included sepsis step by step guidance and all the items required to deal with a suspected sepsis patient quickly, such as medicines and fluids. A sepsis lead nurse was in post and a consultant

clinical educator provided further support for junior doctors in managing sepsis. In addition, the trust has a consultant lead for sepsis and a consultant leading an on going quality improvement project. Each day a doctor is on duty who has the responsibility to respond to sepsis alerts.

Resuscitation equipment was available and fit for purpose. It was stored in appropriate trolleys, which were sealed with a tamper evident tag. Staff carried out daily safety checks, which we noted reflected improved practice from our last inspection.

All staff were aware of the location of the emergency equipment and how to use it. However, there was a risk in the waiting and reception areas because there were no trust staff based there with emergency training, such as in the use of the defibrillator. Patients awaiting treatment from ED staff waited in these areas without clinical oversight from the trust team after they became the trust's responsibility following streaming.

Clinical areas were not compliant with the Sharps Instruments in Healthcare Regulations 2013 and the Department of Health and Social Care (DH) Health Technical Memorandum (HTM) 07/01 in relation to the safe management and disposal of healthcare waste. In the acute medical unit (AMU), one sharps bin in a patient area was overfilled, with a filled syringe and sharps visible and stopping the lid closing. The sharps box label had not been completed. There were two similar sharps bins in the ED, which presented a risk to children or patients with reduced mental capacity. The sharps bin on top of the resuscitation trolley in paediatric ED was filled beyond capacity, with used sharps easily accessible.

The waiting area was dirty and infection risks were not effectively managed during our inspection. There was blood on the floor and spilt, dried coffee in a number of areas. There was no antibacterial gel in the waiting area and we did not observe cleaning or 'damp dusting' during our inspection despite a high turnover of patients. Two out of three vending machines in the waiting area were out of order and people waiting did not have access to cold drinks. In AMU a full urine sample bottle remained on the nurse's desk in one bay for three hours during our inspection. We asked a member of staff working in the ward why it was there and they said they did not know and did not make an attempt to find out. After our inspection the trust told us they had removed the antibacterial gel dispenser from the ED waiting room after a patient had damaged it and they were awaiting delivery of a replacement.

The ED did not have facilities to provide care for patients with significant mental health needs. Staff had very limited options to be able to safely accommodate patients awaiting review. For example, one patient was brought to the department by police with complex needs relating to intentional self-harm, child safeguarding and domestic abuse. The patient was threatening in behaviour and presented a risk to themselves, other patients and staff. However, the single mental health room was in use and the department was operating beyond capacity. Staff in the AMU described previous serious incidents that involved patients with mental health needs that occurred in part because of a lack of resources and training.

Assessing and responding to patient risk

Risks to patients were not always assessed promptly and they were not consistently supported to stay safe.

Clinical staff did not have appropriate oversight of the condition of patients presenting in the department who were streamed to the ED team. This was because there was no clinical member of staff, such as a nurse practitioner, based with the reception team, which was provided by another organisation. We saw that when they needed support they did not have a named and immediate point of contact in the ED. The individual who needed help had to leave reception and find a nurse in the ED who had time to help them. While the reception team's practice and skills were not the responsibility of the trust, the lack of immediate clinical oversight for the trust's patients meant there was an unmitigated risk.

Staff had inconsistent access to care pathway guidelines and some were out of date, such as the stroke pathway. Staff did not always use appropriate guidelines when planning and delivering care. For example, one patient had suffered a fractured neck of femur. Although nurses were providing a good standard of care, they had not used the Royal College of Emergency Medicine (RCEM) guidelines for this and told us this was because they were not readily accessible.

Urgent and emergency services

Royal College of Paediatrics and Child Health (RCPCH) standards state that all children should be visually assessed by a doctor or nurse and have a clinical assessment within 15 minutes. There should also be an escalation policy if triage wait exceeds this as delays can have serious consequences, especially for young children. The ED did not meet these requirements.

We spoke with a nurse practitioner in the ambulatory emergency care (AEC) unit. GPs from the urgent care centre (UCC) had called them to refer seven patients on the day of our inspection who had been inappropriately streamed to them from ED reception. In each case the GP felt the patient's condition was too serious to be dealt with in UCC and needed more clinical input. This added to the workload of the AEC team and was evidence of the increased pressure the system placed on the trust team.

The ED had a triage system which was aligned to a nationally recognised triage system. This categorised patients according to a risk rating of one to five in an initial assessment. For example, level two was a threat to life which required immediate nurse assessment and to see a doctor within 15 minutes; and level four was a moderate risk, to see a nurse within one hour and a doctor within two hours. In December 2018 the median time to initial assessment was eight minutes compared to the England average of nine minutes.

The triage system was nurse-led, with consultant support, and took place in an initial assessment area and the RAT area for patients who presented on foot or in one of two trolley bays for those brought to the ED by ambulance. During our inspection we observed only one nurse allocated for triaging all the walk-in patients, which caused a significant delay due to increased demand. For example, on the day of our inspection the average time to triage was 35 minutes, with 33% triaged within 15 minutes and 6% of patients waiting longer than one hour. Due to crowding, we observed a significant delay in these patients being seen by a doctor. However, the trust told us there were six qualified nurses and three emergency department assistants in triage on the day of our inspection with two senior staff nurse coordinators. We were unable to establish why only one nurse was triaging walk-in patients for the duration of our inspection.

RCEM recommendations state that initial clinical assessment should take place within 15 minutes. This was achieved in three of the 18 patient records we looked at. The department had improved performance in this measure for patients arriving by ambulance by opening two triage bays. From October 2017 to October 2018 the time from arrival by ambulance to initial assessment improved from 17 minutes to 12 minutes.

A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the ED until they are handed over to staff. From October 2017 to late October 2018, the trust reported 3.2% of ambulance arrivals as 'black breaches.' This was an improvement from the 2017 figure of 5.7% and better than the national average of 5.1%. From 24 December 2018 to 6 January 2019 1.6% of ambulances had handovers over 60 minutes which was similar to England which had 2.4% in the same period

All staff we spoke with knew how to raise the alarm and seek urgent help in an emergency situation. However, systems were not in place to ensure this process was time efficient. For example, during our inspection a patient collapsed in the waiting room. The reception team did not have an immediate means of calling for help as there were no panic alarms fitted. Instead a receptionist had to leave their desk and go into ED to ask for a nurse or doctor.

Patients received a comprehensive assessment in line with clinical pathways and protocols. Patients were assessed using a combined form which contained a medical admission and nursing admission template. This included sections for clinical observations, the Glasgow coma scale and details of past medical history, complaint history and a section for treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations. We reviewed 18 records to check the standard of completion, including the patient safety checklist, which was a critically important document. In five out of 18 cases we found incomplete checklists and pathways that had not been started, including two missing sepsis pathways.

The national early warning score (NEWS) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). We looked at 18 NEWS charts in ED and saw that they were

completed correctly and regularly updated. NEWS is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. On 17 of the charts reviewed, clinical observations were repeated in line with the previous score and escalated when scores were elevated. We found one patient who had an escalating NEWS score that staff had not acted on. We spoke with a nurse about this who attended to the patient immediately. We saw on AMU staff had calculated NEWS correctly but had not noted the action they had taken when a patient had repeatedly triggered the escalation point for senior review.

Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. We looked at the records of nine patients in the department who had the sepsis pathway implemented. All charts we reviewed showed diagnostic and initial treatment was completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) Sepsis: recognition, diagnosis and early management.

We looked at the documentation for one patient in AMU because we had concerns about the knowledge of staff relating to their condition following our observation of violent behaviour. Staff told us the patient was generally settled and had not shown any aggression previously. However, we found from looking at nursing notes that the patient had frequently been aggressive or violent, including verbally abusing staff and refusing to engage with observations. Staff on duty we spoke with were unaware of this despite some of the entries relating to the same day.

The waiting room for the ED was overcrowded for most of our inspection, with patients sitting on the floor and tempers clearly fraying. There was no staff presence in the waiting area except when the triage nurse entered to find a patient. Patients experiencing a mental health crisis and adults under the influence of alcohol were accommodated next to children. We observed people arguing with each other and shouting offensive language. One patient who had been verbally abusive to staff lay on the window ledge in the waiting area and started screaming for attention. Reception staff and clinical staff walking through the area ignored them. We observed parents of children and relatives of elderly patients waiting become very distressed on four occasions and leave the waiting area to find somewhere else to wait. There was no mechanism to observe ill patients in the waiting areas as it was away from receptionist view. Although a patient and staff safety team was available on call there was no visual presence in the waiting area during our inspection.

The paediatric ED had a dedicated waiting area, which segregated children from adults. However, during our inspection we observed children waiting to be triaged were sometimes initially accommodated in the adult ED waiting area. After our inspection the trust told us the reception team, who were not employed by the trust, always offered parents the option to wait with their children in the dedicated area.

We observed patients being treated in resus and the RAT area and waiting in the corridor in front of the RAT area to be treated. Once the patient was moved into resus or RAT they were seen by a consultant or middle grade doctor and the management was appropriate to the condition. We observed eight critically ill patients in resus and staff managed their conditions adequately.

We reviewed 10 sets of notes and found a significant delay in moving patients out of resus for reasons such as a lack of monitored beds in majors, not enough trolley spaces in majors and the RAT area and a lack of specialty medical beds in the hospital. This had the potential for a significant impact on caring for critically ill patients.

At one point in our inspection there were 75 patients in the emergency department, most of them waiting in the waiting room, with 14 patients in the corridor on trolleys and some others were sitting in front of the RAT area. Our notes review suggested there were gaps in regular observations of patients in majors and it was difficult for staff in majors to monitor patients out of view.

We reviewed the time from arrival to initial assessment for 18 patients who arrived in the previous 14 hours during our inspection. The average time was 38 minutes, which reflected wide variations, from three minutes to three hours and 34 minutes. This reflected the significant additional pressures on the ED overnight as two patients who had presented between 12am and 2am each waited over one hour for initial assessment.

This department did not have suitably trained staff or the resources to adequately care for patients with mental health issues. We observed a patient in the waiting room

experiencing mental health symptoms that were not addressed by staff. In the ED we observed a patient with serious mental health problems waiting for a long period of time to be assessed by the mental health team. They were on their own, moving in and out of their trolley area crying and begging for help. The nurse looking after the patient was busy with several other patients and was unable to comfort them. The nurse became very upset with the situation and one of their colleagues had to take them aside to provide support. We spoke with senior staff about this who said they recognised the significant lack of mental health provision. The mental health liaison team was provided by another organisation. This was a nurse-led service, with psychiatrist input on request, provided by an experienced team of senior mental health nurses. The service standard was to review all patients in ED within one hour of referral. However, the trust did not have continual oversight of the performance of this service and delays had a direct impact on the safety and wellbeing of patients under their care.

There were no consistent mitigating strategies in place to reduce the risk to patients whilst waiting for assessment or review or for those waiting admission. For example, one patient had been cared for in the corridor for over five hours. During this time staff had not assessed them for pressure area risks, carried out skin assessments or a nutrition and hydration assessment. Another patient living with severe dementia had been accommodated in the corridor for over eight hours. Staff had not carried out a skin bundle assessment, pressure area assessment or offered snacks and drinks. After our inspection the trust said a team of volunteers worked in ED and offered food and drink to patients and their relatives. They provided evidence this system was in place on the day of our inspection but we were unable to identify why this had not included the patients we spoke with or observed.

Out of the 18 patient records we reviewed, staff had not documented allergy information for seven patients. This included one patient who was allergic to steroid cream. This was noted on the paramedic assessment sheet but ED staff had not copied it onto the patient's records. In each case staff had administered pain medicine and antibiotics appropriately.

The AMU team had acted on a significantly higher prevalence of HIV in the local population than the national average, at 3.6 infections per 1000 instead of two per 1000 nationally. A dedicated HIV support worker was in post and supported staff to test every patient on admission. This followed national best practice guidelines to avoid the risk of undiagnosed HIV from the British HIV Association and the British Association for Sexual Health and HIV.

Nurses completed life support training at a level commensurate with their experience and level of responsibility. At the time of our inspection 82% of nurses had up to date paediatric basic life support (BLS) training and 75% had adult BLS. Senior staff were unable to confirm completion rates for immediate life support or advanced life support training.

Staff demonstrated good understanding of safeguarding principles although the crowded nature of the department and unmonitored waiting room presented significant safeguarding risks. We spoke with a patient and staff safety officer who said their team was often called upon to assist in child protection cases where staff were concerned about the behaviour of parents in the department. Amongst the nursing team 81% had up to date child safeguarding training from levels 1 to 3 and 72% had up to date adult safeguarding training from levels 2 to 3.

Staff carried out regular safety huddles to review the capacity of the department and address immediate risks to individual patients. We attended a safety huddle as part of our inspection. Although not all doctors were present the team had a good understanding of the key pressures, such as a patient who had been waiting for a mental health admission for over 17 hours. This was outside of the trust's control as mental health services were provided by another organisation although patients remained the responsibility of the ED team whilst awaiting specialist review.

Nursing staffing

There were not always enough nursing staff to keep patients safe from avoidable harm and to provide the right care. However, nurses had the right qualifications, skills, training and experience.

The emergency department used a combination of the baseline emergency staffing tool and the NICE emergency department staffing recommendations to ensure the department was staffed appropriately. This outlines how many registered nurses they needed to safely staff the

department. The tools looked at the acuity of patients and how many were in the department at certain times of the day. As a result, the department had changed some shifts to provide a safe amount of staff at the busiest times of the day. However, we did not see evidence this system responded to increases in demand during a shift. For example, at one point during our inspection one nurse was responsible for 12 patients being cared for in the corridor.

We looked at the nursing rota for a sample of eight days in the previous three weeks. The number of registered nurses on shift during the day varied from eight to 16 and overnight this varied from eight nurses to 11 nurses.

There were always two trained nurses in resus, which met the nurse to patient ratio standard of 1:2 set by the Royal College of Nursing.

Four trainee advanced care practitioners in the department provided support during peak times.

At all times during our inspection, we found the skill mix of staff to be suitable for the needs of the ED, with actual staffing levels meeting the planned levels. Senior staff had oversight of staffing in the department and moved staff around to ensure all areas were safe and they were able to manage surges in demand. However, this did not always apply to patients being cared for in the corridor and the nurse to patient ratio was up to 1:12. Nurse practitioners and staff nurses led care in the AEC unit. However, the nurse practitioners spent a significant amount of time responding to GP referrals, which reduced their clinical role. Where the AEC was opened overnight to accommodate patients during periods of high demand, a nurse and two healthcare assistants were redeployed from the AMU. However, we spoke with staff who said the AMU was often short-staffed and so a nurse was taken from other inpatient wards. In one instance recently, this had left one inpatient medical ward with one nurse to care for 14 patients. After our inspection the trust said they were unaware of this occurrence because staff had not reported it as an incident.

The matron had introduced a new debrief procedure to help support nurses affected by extremely high workloads on a continual basis. Nurses said this had been an effective support process and had reduced sickness.

A mental health liaison team, staffed by senior nurses, was provided by another organisation. Their service level agreement indicated one senior nurse was always available in the ED to review patients and one senior nurse was always available in the mental health decision unit. However, due to short staffing caused by sickness, maternity leave and secondments, the liaison team was unable to always provide cover and the ED did not have nurses or other healthcare professionals trained in mental health

Nurses did not have appropriate training to be able to care for patients who presented with acute mental health needs. Staff in the ED and in AMU said they frequently saw younger patients who had overdosed intentionally or who were at risk of suicide. One senior nurse said, “We don’t have the training or knowledge to be able to deal with this. It can be frightening not to be able to help someone.”

There was a separate paediatric ED, with audio visual separation from the adults ED, open 24 hours a day. This was staffed by ED paediatric registered nurses. Overnight, the paediatric department was staffed by one paediatric ED nurse, which was not in line with RCPCH standards.

A GP practice nurse had been recruited by the AMU to transfer patients from the ED to the AMU when they no longer needed urgent care. This was a strategy for better use of nurse staffing to improve flow although we did not observe this directly in practice.

Medical staffing

There were not always enough medical staff to keep patients safe from avoidable harm and to provide the right care. Medical staff had the right qualifications, skills, training and experience.

Senior medical staffing levels in the ED were not adequate to meet demand. A team of 13 whole time equivalent (WTE) consultants provided care from 8am to 10pm. This did not meet the RCEM recommendation of a minimum of 16 hours consultant cover per day although the trust set a compliance standard for this measure of 88%, which they had met from October 2018 to January 2019. Only 2.5 WTE consultants were registered on the GMC Specialist Register, the rest were locum consultants. Locum staff had completed inductions and had appropriate access to support. At a weekend there was one consultant on duty from 8am to 1pm. The trust had recruited two consultants registered on the GMC

Specialist Register who were due to commence their posts in March 2019. A further two substantive consultants were due to return from sabbatical in June 2019 and July 2019.

Although there was a need for improvements in senior medical staffing, the trust had been improving standards in the previous 12 months. This meant the ED would meet 95% compliance by March 2019 and reflected a substantial improvement since our last inspection. In the 10 months leading to our inspection the trust had achieved between 83% to 93% compliance and had recruited to a consultant post, which would leave a vacancy rate of 1.5WTE from March 2019.

A registrar was based in the AEC from 8am to 8pm on Mondays and one registrar and one consultant was based in the unit from 9am to 5pm Tuesdays to Fridays.

A team of up to four consultants led care in the AMU. A frailty consultant was based in the AMU Monday to Friday and cared for patients with two or more chronic conditions. There was limited input for patients who required a frailty review in AEC.

Junior doctors spoke positively about working in the emergency department. They told us consultants were supportive and always accessible and that the implementation of a clinical lead for education on each dayshift helped them to access support and guidance quickly. This was an improvement on previous feedback from junior doctors through the General Medical Council, who had noted a lack of support.

The clinical lead for each shift was responsible for ensuring junior doctors were supported and clinical educators were on shift three days per week to provide supernumerary support to clinicians.

The department saw approximately 15,000 children per year but did not have a paediatric emergency medicine consultant in place, which was against RCPCH standards. The trust did not have a workforce plan in place to address this issue and where children needed a consultant review they were redirected to the children's assessment unit. However, this unit did not operate 24 hours and meant a paediatric consultant was not always available.

There were five higher specialist trainee (ST) grade doctors at level ST4 and six at basic level ST3 in ED. From 10pm to 8am one ST4 covered the whole ED, which was a significant level of

responsibility. Although they were usually supported by one or two ST3 doctors, all the doctors we spoke with said it was too onerous for one ST4 to cover the busy department, including paediatrics, overnight. Two doctors mentioned during recent shifts it had not been possible to have a break throughout the nightshift, which meant they worked for 10 hours continuously without a break. Doctors said they had not submitted exception reports for these instances, which meant the trust did not have oversight of those working excessive and unsafe

hours. This was compounded by the fact that at times there was only one medical ST4 covering the whole hospital including ED, sometimes without adequate junior cover. The ST4 was also responsible for AMU, which saw patients with high levels of acuity.

Middle grade doctors said that except for the issue with night cover, they were happy working in the department and felt they had adequate senior support and had received a 'good' induction.

The senior doctor rota suggested that more than 60% of the shifts were covered by locums. One consultant, one specialist registrar and one junior doctor staffed resus. Overnight this was led by the registrar as there was no consultant present.

Doctors described a continuous culture of teaching supported by the consultant allocated for educational support and not clinical service. This consultant had started a daily education board featuring useful tips on specific conditions such as hyperkalaemia.

Are urgent and emergency services caring?

Compassionate care

Staff did not consistently care for patients with compassion.

Staff in the emergency department (ED) and the ambulatory emergency care (AEC) unit were consistently compassionate and caring. In the acute medical unit

(AMU), some staff demonstrated kindness and a caring approach although this was not consistent. For example, we observed an angry verbal argument between a patient and their relative. This escalated and the patient physically assaulted their relative. Four members of staff were present in the bay but appeared to ignore the altercation. A healthcare assistant (HCA) was sitting with a patient opposite the incident and shouted across the room that they needed to be quiet and stop swearing. The relative asked a passing HCA for assistance but this member of staff shrugged their shoulders and curtly said, "I'm not an HCA on this ward", before walking away. This confused the relative who did not understand the different types of staff present. A trainee assistant practitioner (TAP) watched the altercation and did not intervene and a charge nurse continued attending to another patient without getting involved. We asked the TAP for information on the patient but they said they did not know if this was usual behaviour for them. The patient's relative, who was very upset, asked the TAP for help but was told it was their fault for upsetting the patient and suggested they left the ward. Our inspector intervened at this stage and contacted the matron. This incident demonstrated a significant lack of compassion, understanding and kindness. Staff failed to act on a situation that presented substantial risks to both patient and relative and did not recognise warning signs that were clear before the situation became violent.

An HCA on the AMU was sitting with a patient to provide one-to-one support. The body language of the HCA was defensive and they appeared to be bored, spending lengthy periods staring out of the window and ignoring the patient. The patient was confused and repeatedly tried to stand up. The HCA did not attempt to engage the patient in conversation and did not demonstrate any skills that suggested they had communication training. The relative of this patient asked the TAP if there was a male member of staff who could help them to have a shave as they were upset at the personal appearance and hygiene of the patient. The TAP was dismissive and said if they could find a razor blade and shaving cream then anyone could help them to shave. This did not address the request that the relative said the patient would prefer support from a male member of staff, despite several male staff being on duty.

We discussed our observations with the ward manager and matron who said this was not the standard of care they expected and they took action immediately with the staff involved. They explained all staff had completed training on de-escalating situations in which patients or relatives were upset. The ward manager attended to both patients and discussed their care plans with them, including with their relatives.

In the ED we observed staff responded quickly to patient call bells although crowding of the department meant staff did not always notice when patients needed attention in the corridor. We observed a patient under the influence of alcohol pacing the corridor and shouting, which clearly frightened two elderly patients who had been left unattended.

One patient in the ED said, "Staff are always hardworking and so busy. They're excellent." Another patient said, "I'm very grateful to the hospital staff, they have all been lovely."

We spoke with a patient who was being cared for in the corridor, along with their relative. They had been in the corridor for over five hours and told us they felt there was a lack of dignity. The patient said, "The doctor examined me [intimately] here in the corridor. There's no screens, no privacy."

We observed in AEC staff were kind and friendly with patients and used good humour to reduce frustrations at delays. Staff also demonstrated efforts above and beyond their expected duties to deliver a high standard of care. For example, one patient needed the results of blood tests before they could go home safely. These had been significantly delayed due to long waits in pathology. The nurse practitioner in charge of the AEC had stayed over one hour past their paid finish time to wait with the patient and provide reassurance, who was becoming increasingly frustrated at the delay.

Understanding and involvement of patients and those close to them

Staff did not consistently involve patients and those close to them in decisions about their care and treatment.

On the AMU we did not see all staff had an understanding of the needs of patients and their relatives. For example, a distressed relative asked a TAP for information on the plan for their family member, who had become increasingly frustrated and angry. The TAP said they did

not know what was happening and they would, "…just have to wait." The charge nurse sat with the patient and their relative briefly before a violent altercation but was unable to help. For example, the patient's relative wanted more information on their condition and what was happening but the nurse said, "I don't know what else I can tell you", before leaving the bedside.

We observed the AMU ward manager spend time with a relative whose family member was being transferred but did not understand why. The ward manager was kind and gentle and explained in simple terms why the transfer was the best option and why it meant their family member would receive more appropriate care. They also explained why a physiotherapist had prepared a care plan and took the time to explain what it meant and explained why staff had talked about a 'baseline', using humour and dignity to present this. Baseline refers to the usual physical condition of the patient, which staff aim to return to through medical intervention. Both the patient and their relative had previously been agitated and verbally frustrated, repeatedly asking a healthcare assistant for information who did not meaningfully engage with them. We saw both individuals were much calmer and happier after their discussion with the ward manager.

In 13 out of 18 patient records we looked at in ED staff had documented a discussion with the patient or a relative. Two patients in ED said they had discussed their care and treatment with a doctor and said they understood the next steps. We spoke with the relatives of a patient who had been in ED for nine hours. They were very complimentary of staff and said they had been kept informed of the reasons for the delay. One patient we spoke with said staff seemed too busy to be able to ask for information so they had not asked any questions despite being in the ED for over six hours.

Staff had not offered patients waiting in the corridor basic comforts, such as drinks or snacks. We spoke with a patient who said they were very thirsty after being there for five hours but staff had not offered them a drink and they did not feel they could bother them because they were so busy. We spoke with the relative of an elderly patient who had been in the corridor on a trolley for over eight hours. They said, "Nurses are kind but too busy to do anything. I'm worried [my relative] hasn't had a single skin check or pressure check and no-one has offered a drink." After our inspection the trust provided evidence volunteers had offered food on two occasions and drinks on one occasion between 1pm and 6pm on the day of our inspection. Volunteers used a template to record the location of each patient they offered food or drink to and whether they had accepted the offer. We were unable to establish why this had not included the patients we spoke with or observed.

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

Access and flow

Patients could not always access the service when they needed to.

There were systems in place to manage the flow of patients through the emergency department (ED) to discharge or admit to the hospital but these did not function adequately or consistently. There was very limited communication between acute physicians and doctors from medical specialties and the ED team, which resulted in considerable delays in admitting patients to medical and surgical wards.

The operations control room and clinical site team could see on the IT system the length of time patients had been in the ED, who had been referred and who was awaiting admission. The system allowed them to have an overview of bed availability and the flow of patients coming into the ED. The team discussed this at regular bed meetings throughout the day and made plans to address it.

The directorate manager, flow coordinator and ED nurse coordinator worked together to identify patients waiting for admission or transfer. We saw evidence of effective communication amongst this team during our inspection. The general manager, divisional lead nurse and interim executive for unplanned care attended the department frequently during busy times to support flow. However, there was limited action at bed meetings due to a lack of communication with medical teams and the lack of beds available on wards.

Two ambulance triage bays had been implemented to reduce handover delays from paramedics. A corridor was also used to accommodate patients during periods of

high demand and a nurse was assigned to care for these patients. However, we saw up to 12 patients could be accommodated in the corridor, which meant the nurse had limited capacity to monitor each of them. Senior staff told us there was a full capacity protocol in line with Royal College of Emergency Medicine (RCEM) guidance but we did not see evidence of this in practice. The ambulatory emergency care (AEC) unit was designed to provide care for patients during daytimes only. However, due to exceptional demand on the trust, the site team had opened the unit to provide additional capacity overnight on two occasions in the previous three months. On the day of our inspection the site team made the decision to keep the AEC open, which would provide overnight capacity for up to eight patients.

A five-bedded area designated as assessment B operated on a clinic model with a designated mental health room and space for seated patients to increase capacity.

The consultant team had increased the range of services they offered in the AEC to reduce pressure on the ED and to reduce the need for admission, such as blood transfusions and lumbar punctures.

The Department of Health and Social Care sets a national standard that all patients who present to an ED should be seen and assessed and admitted or discharged within four hours. The trust achieved this for 64.4% of patients in December 2018, which was much worse than the standard and worse than the national average of 79.3% but better than the trust's performance of 40.1% in December 2017. The trust performed much worse than the national average for this measure for patients seen only in ED majors, with only 58.9% of patients spending less than four hours in the department compared with 83.2% nationally.

Frailty consultants worked with nurse practitioners to reduce the length of stay of frail patients and to keep them at home safely and comfortably. Where patients were admitted to AMU, the frailty team provided an in-reach service to assess them and plan discharge with the community and home care team.

A new flow manager post had been implemented in October 2018 and this individual was working with their team to improve access and flow through the hospital. They had established the control room as a base for bed and capacity meetings that now included all hospital departments. They had piloted the use of a new ED escalation plan, which included new criteria to identify when the department was under exceptional levels of demand, using the NHS England operational pressures escalation levels framework (OPEL). We observed a bed meeting and spoke with the flow manager who said they were working with physicians to adjust the criteria for OPEL as the department rarely saw lower levels of escalation despite some periods of low demand.

During the bed meeting we saw there were over 250 stranded patients in the hospital. NHS Improvement defines a stranded patient through the emergency care improvement programme as a patient with a length of stay of seven days or more. We spoke with the general manager for unplanned care who said a new director of operations was reviewing the processes for stranded patients but recruitment for more staff for inpatient care to address this had not yet been successful.

Staff used a 'step across' pathway for patients admitted to ED with social care needs. This enabled staff to liaise with colleagues at a facility in the trust equipped for social care. Senior staff described this pathway and said it was active but during our inspection there was no evidence patients with social care needs had been identified for care under it.

The trust had established a synergy vehicle service for patients who called 999 in an emergency with mental health needs. A mental health crisis worker, a paramedic and a police officer staffed the response vehicle, which had prevented seven ED admissions and 17 section 136 admissions in its first week of operation.

Two triage cubicles had been set up for patients who arrived by ambulance as a strategy to reduce ambulance turnaround times. This had significantly reduced the time to handover for patients arriving by ambulance and from November 2018 to January 2019 each patient was handed over within 15 minutes of arrival.

An ambulance liaison officer was in the ED during our inspection and acted as a liaison between ambulance crews and the ED team. We saw this enabled patients to have more direct access to care pathways, such as the chest pain pathway, because it meant they could be rapidly triaged.

Urgent and emergency services

In December 2018, 40% of patients waited from four to 12 hours from the decision to admit to admission time. This was an improvement from 66% in December 2017 and was similar to the national average of 14%.

In December 2018, the trust's monthly median total time in A&E for all patients was 207 minutes which was worse than the England average of 158 minutes

In December 2018 the median time to treatment in the national data set was seven minutes compared to the England average of 60 minutes, although it did not reflect our findings during our inspection.

Patient flow through the department was significantly impacted by the lack of space and infrastructure in majors, including the lack of bays equipped for cardiac monitoring. Other factors also impacted on flow, including the lack of collaborative working between ED and medical specialties, and ineffective and inefficient implementation of an escalation plan.

There was ineffective management of crowding and little evidence of senior oversight of this. For example, the RAT system worked to a certain extent with senior decision makers treating patients. However, due to lack of space and increased demand there were increasing numbers of patients waiting in corridors and in the main waiting room for long periods of time. However, we observed staff move a seriously ill patient with sepsis from the corridor to the RAT area who was assessed and treated appropriately by a senior doctor.

AEC was unable to provide additional capacity and support to ED due to a lack of clarity on its scope and the model of care. For example, a senior nurse said, "When it functions AEC might be able to help but there's no senior decision-makers there and it's not really an ambulatory unit."

Fourteen of the 18 patients we reviewed whilst in the ED breached the national four-hour target and some patients spent considerable periods of time there. One patient had been in the department for 16 hours and 30 minutes, another for 14 hours and 30 minutes and another for 12 hours and 30 minutes. A patient awaiting a mental health inpatient bed had waited over 17 hours for review by the mental health service provider. We spoke with the medical team about this who said it was typical to have from 12 to 28 patients waiting for admission at any one time. These patients were therefore occupying space that could be used for waiting patients. At 8pm on the day of our inspection there were 75 patients in the department with a wait to be seen of three hours and 56 minutes.

The hospital had piloted and then introduce a 'golden patient' system to promote discharge earlier in the day for patients with complex social care needs. A matron said this had reduced queues in ED because it cleared beds in inpatient wards by 10am during the pilot. We did not see evidence of this in practice during our inspection, including during the bed meeting. The trust had opened additional beds at another hospital and we saw site staff include these in discharge and transfer planning in the bed meeting.

An integrated assessment team (IAT) team of physiotherapists and occupational therapists were based in the ED Monday to Friday from 8am to 6pm to provide patients with direct access to community care pathways and rehabilitation beds in another hospital.

Staff in AEC described periods of unmanageable workloads. On the day of our inspection the team had successfully discharged or transferred eight patients. Another eight patients were transferred in quick succession and one registered nurse was redeployed by the site team. The nurse team and ward clerk also cared for patients attending consultant clinics on an outpatient basis and took calls throughout the day from GPs who needed help to refer patients. Nurses also provided care for patients who needed intravenous therapy and blood transfusions and who were referred by community clinics because they had a lack of capacity themselves. Nurses were responsible for clerking and prescribing medicines. This resulted in a unit that had no clear focus or place in the hospital system and staff said it felt, "chaotic and overwhelming".

Are urgent and emergency services well-led?

Leadership

Managers at all levels in the trust did not always demonstrate the right skills and abilities to run a service providing high-quality sustainable care.

Urgent and emergency services

The consultant in charge of the emergency department (ED) was capable of managing critically ill patients and supervising the junior doctors. There was good communication between the consultant in charge and the nurse coordinator; however, a lack of co-ordination for the crowding issues was evident. There was a lack of presence of the senior management team in the department to resolve the serious crowding issue and no evidence of multi-disciplinary working, particularly with medical specialties.

Staff in ED spoke positively about local leadership. The said the matron and consultants were approachable and always ready to help. They said that although the department could be a challenging place to work because of crowding and the lack of flow, they never felt alone without a senior member of staff to help.

There was no coordinated leadership for mental health services and no individual who had the authority or access to senior support who could expedite the assessment and transfer of patients experiencing a mental health crisis. After our inspection the trust provided the standard operating procedure for interaction with the mental health provider. This was evidence of an established relationship but we did not see it worked in practice during our inspection.

Leadership in the acute medical unit (AMU) and in the emergency ambulatory unit (AEC) was not always apparent. For example, a nurse in the AEC had stayed more than one hour past the end of their paid shift because of delays in obtaining blood results for a patient. There was no senior oversight of this and staff in AEC told us they were usually, "left alone", which meant there was no consistent senior management presence. In AMU we observed staff in one bay demonstrably struggle to cope with patient demand but they had not asked the ward manager or matron for help. When the ward manager was working clinically in the ward we saw there was a significant improvement in standards of care and communication.

Vision and strategy for this service

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Senior staff acknowledged a need for more effective care pathways that linked services together, such as the ED team with the mental health liaison team. The division had recently held a 'big room' event that brought together staff in different roles to discuss their perception of pathways versus the reality. This began work to adapt pathways to patient needs rather than forcing patients with varying conditions into a strict pathway. However, the lack of cohesiveness in working relationships between doctors from medical specialties meant there was limited evidence of improvement in the use of pathways during our inspection.

The general manager described the work underway to improve compliance with internal professional standards, particularly with orthopaedics and cardiology. This included work to improve understanding of the AEC unit across the hospital, which had recently changed name from the combined assessment and treatment unit, to help staff better understand its purpose. They were working with ED colleagues to develop an integrated ED/AEC pathway so that when patients arrived in the ED, acute physicians could admit the patients for their specialty and other patients would be streamed to AEC. NHS Improvement describe internal professional standards as clear, unambiguous values and behaviours expected in an organisation that are centred on patient care and actively led by clinicians and the executive team. The department did not have systems in place to monitor delays relating to individual specialties. However, after our inspection the trust upgraded systems to ensure this would begin immediately. In addition, the medical director and director of nursing had led a series of briefing sessions for staff across the hospital to better articulate requirements and expectations of internal professional standards. The medical director was further addressing this through the clinical policy forum.

There was no evidence of a coordinated strategy between ED, AEC, AMU and the mental health decision unit (MHDU). A senior manager in unplanned care said patients could be redirected from ED to the MHDU to help prevent deterioration of their mental health condition while waiting for a specialist review. However, a senior member of the mental health team said this was not part of the service level agreement and patients would never be seen in the MHDU before first being assessed in ED, even if this meant they had a more appropriate place to wait.

Urgent and emergency services

Governance, risk management and quality measurement

The trust used a systematic approach aimed at continually improving the quality of its services and safeguarding high standards of care. This was not consistently effective.

The streaming service and urgent care centre (UCC) were operated by another organisation. The ED matron maintained oversight of streaming protocols and the training of the team and senior staff from both organisations met monthly as part of a shared governance approach. For example, senior teams from both organisations had reviewed the efficacy of the streaming service following a Freedom to Speak Up incident. However, we were not assured that senior trust staff had an understanding of the risks in the streaming service, including those related to a lack of clinical training in the reception team.

The general manager for unplanned care had introduced bi-weekly ED improvement group meetings to improve engagement. They used NHS Improvement methodologies to identify and test change and improvement projects with the team.

We observed a good working relationship between the ED team and paramedics from the local ambulance service. Senior staff said teams from both organisations were working together through joint governance structures to identify more effective ways of working together.

Consultants, middle grade doctors and junior doctors held mortality review meetings every two weeks. Doctors said these were effective in reviewing care and identifying opportunities for improvement. Morbidity and mortality meetings were not minuted although a senior clinician prepared a summary of learning and prepared a newsletter-style update for all staff. We reviewed the three most recent cases being prepared for a mortality review. In one instance a patient had died in the department after the cardiology service declined a referral and ED staff had not identified changes in an echocardiogram at triage.

After our inspection we asked the trust for a sample of recent governance meeting minutes. This was to review the structure and effectiveness of processes used to manage relationship with other organisations providing services to the trust's patients, including the reception streaming service and the mental health liaison service.

Governance and performance meeting minutes for October 2018 indicated the trust did not have routine oversight of the number of patients streamed to the UCC and then returned to the ED. We identified this as a key risk during our inspection. The meeting also indicated that basic elements of care in some outsourced services were not well-established. For example, the trust's pharmacy team confirmed in the meeting that it was the responsibility of the mental health provider to prescribe medicines to patients in the mental health decision unit. This meeting indicated there had been 16 mental health patients with a decision to admit delay of over 12 hours in the previous month.

A mental health partnership meeting met in November 2018. This was a multidisciplinary group that included representatives from the trust, the ED, the mental health provider and the police. The meeting provided evidence of the challenges caused by a lack of staff and capacity but did not provide assurance of substantive plans for improvement. For example, the meeting noted a pilot week to improve triage for mental health patients had been cancelled due to short staffing in the mental health team, who were not employed by the trust. While the group planned to try and operate this again they noted persistent pressures on staffing could not guarantee it would go ahead.

Five members of staff in the ED described increasing instances of aggression or violence in which the safety of staff or other patients had been jeopardised. During our inspection we witnessed instances of patients behaving abusively to staff. A dedicated patient and staff safety team provided an on-call response. Members of this team we spoke with described increasing challenges in managing aggression and violence in the ED, including an incident in which a patient tried to use infected blood as a biological weapon against staff and instances of targeting of staff in the local community when off-duty After our inspection the trust said they were unaware of the intentional use of bodily fluids to threaten staff during

an incident but one officer had been put at risk by not following correct procedures to use personal protective equipment. We were unable to reconcile the differences in accounts between staff and the trust.

Culture within the service

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We observed positive working relationships between staff in ED and the team in AEC and staff actively supported each other when the department became very crowded. Staff said they had sustained morale over the winter period to date and the presence of divisional managers and lead nurses had helped this.

All the ED staff we spoke with said they liked working in the department and felt well supported and looked after. One nurse said, "I love working here. I think we're very focused on patient care and there is a good team environment. I can ask for advice at anytime and I've been given more training here than I was ever offered working on the wards." Another nurse said, "Every day is different, that's what's so good about working here." Staff said there was no hierarchy and they appreciated being able to challenge decisions and discuss their thoughts and ideas.

All staff acknowledged the lack of space as a key challenge and frustration and said they felt the standard of care they could deliver was affected by this. For example, one nurse said there was a limit to the quality of care they could provide to patients waiting in the corridor. However, staff also said they provided water, hot drinks and snacks to patients waiting in the corridor. We saw variable evidence of this during our inspection.

In 2018 the ED team was awarded with the trust's chairman award in recognition of their improvement work and resilience. The matron had introduced a weekly peer-nominated staff award for everyone working in the department as a further strategy to improve working conditions and boost morale.

Outstanding practice and areas for improvement

Outstanding practice

- Senior emergency department staff had introduced more consistent support for staff following an incident, including a 'support basket' with items to encourage staff to come together and debrief for 15 minutes. Staff spoke highly of this initiative and said it helped them to focus again on patient care after a stressful period or incident.
- The trust had facilitated the implementation of a 'psynergy car' service for patients who called 999 with urgent mental health needs. The service was staffed by a police officer, mental health crisis worker and a paramedic. In its first week of operation the psynergy service had prevented seven unnecessary ED attendances and 17 attendances for patients detained under section 136 of the Mental Health Act.
- Although nurses lacked formal training in the management of mental health conditions, they demonstrated exceptional resilience and compassion when faced with patients who were clearly deteriorating. This included a nurse who remained kind and compassionate despite a patient screaming in their face after being in the department for 17 hours.

Areas for improvement

Action the hospital MUST take to improve

- Further improve performance in the national 15-minute triage recommendation.
- Improve standards of care, including triage, time to assessment and time to mental health review, for patients with mental health needs.
- Ensure the paediatric ED is compliant with RCPCH staffing level standards.
- Ensure consultant staffing in the adult ED meets the minimum requirements of RCEM.
- Ensure the availability of medical staffing in ED overnight is sufficient to meet demand.
- Ensure the service meets the needs of patients who present with a mental health need.
- Ensure the ED waiting room and throughout is monitored for safety and overcrowding.
- Ensure the security of the ED and AMU is assured at all times.
- Ensure children waiting to be seen are accommodated in a safe, appropriate environment.
- Ensure governance processes are fit for purpose and contribute to productive, effective working relationships with providers relied on to deliver patient care.
- Ensure there is a robust, structured strategy to improve internal professional standards for the admission of patients to specialty services.

Action the hospital SHOULD take to improve

- Improve governance processes and clinical governance oversight of the number of patients treated in the ED following refused care in the urgent care centre.
- Improve the management of the waiting area in the main ED to ensure patients who are vulnerable are not put at risk by patients who pose a threat to their safety.
- Continue to work in partnership with the mental health provider and other providers to review the tools used to assess and improve the mental health pathway.
- Ensure staff working in the acute medical unit have the training and supervision to provide a caring and compassionate service.
- Effectively manage crowding in all areas of the ED.
- Review the flow of patients through the paediatric ED to reduce the time children spend waiting with adults.
- Ensure there is a clear, defined and ratified standard operating procedure for the ambulatory emergency care unit and ensure that staff understand this and adhere to it.
- Ensure patients have access to food and fluids during their time in the department.

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Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care was not always person-centred and did not always meet individual needs. Staff did not always make reasonable adjustments to the service to meet individual needs:** • Patients and their relatives had to sit on the floor in the waiting room because of a lack of capacity and there were limited adjustments for children, patients living with dementia and patients with mental health needs. • Children were not always immediately accommodated in the paediatric emergency department waiting area and sometimes had to wait with adult patients until they were triaged. • Adjustments were not always made for patients who presented with a mental health condition while awaiting review by the mental health liaison team. This included a patient awaiting a mental health review who was left without monitoring in the waiting room and whose behaviour escalated and caused distress to other patients. • Staff failed to act on an escalating violent situation in the acute medical unit (AMU), which resulted in a relative being assaulted. This reflected inappropriate care that did not meet their needs. • There was a lack of privacy and dignity for patients being cared for in the emergency department corridor. This included an elderly patient living with dementia who was left without appropriate monitoring for five hours. The patient was confused, disorientated and distressed and staff had not regularly offered liquids.

Regulated activity	Regulation

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Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not always delivered safely:** • Patients were cared for in a corridor during times of exceptional demand. Although a qualified nurse and an emergency department assistant were assigned to care for these patients, the number of patients regularly exceeded the maximum number set by the trust. Not all patients accommodated in the corridor had a nurse call bell. In December 2017 we told the trust they must improve the care and safety of patients cared for in the corridor. In response the trust had implemented a standard operating procedure for the care of patients in the corridor but staff did not always adhere to this. For example, we saw one patient with an escalating national early warning score (NEWS) who staff had not attended to and an elderly patient living with dementia. • Staff in the acute medical unit did not always ensure the safe care of vulnerable patients at risk or of those living with mental health conditions. During our inspection one patient assaulted a visiting relative. Staff failed to act on clear signs of escalation and had not accurately documented the mental health needs of the patient. Staff had not taken reasonable steps to mitigate this risk, which were pre-existing and which staff were already aware of. The service had failed to assess the health and safety to the patient or their visitor based on known risks and staff responsible for delivering care did not demonstrate competence to deliver appropriate care.
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises were not always secure, suitable for the purpose for which they were being used and properly used:** • Staff had disabled the electronic access system to the main emergency department to improve access for patients moving between the urgent care centre and

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the x-ray department. Patient and staff safety officers were available on-site but did not have continuous monitoring systems for people accessing the emergency department. This meant there was unmonitored access to clinical areas, including to patients with mental health needs and those with conditions that made them vulnerable.

- Capacity in the emergency department did not meet demand on the service:
  - The waiting room was continually overcrowded, with patients sitting on the floor and in the adjacent corridors.
  - The majors area was overcrowded with corridor space used for storage, which impeded access for patients on trolleys and beds and partially obstructed emergency exits. After our inspection the trust told us this was a temporary measure following a significant increase in demand.
  - Only two patient bays in the majors area had monitoring equipment. This meant staff cared for patients at high risk of deterioration in the resuscitation bay. This reduced the ability of the service to provide clinical space for patients who needed enhanced monitoring and for those who needed resuscitation.
  - There was one designated side room in the emergency department for patients with mental health needs. Patients spent significant periods of time here and there were no alternatives available for other patients who needed quiet or more private waiting spaces.
- The emergency ambulatory unit was a short-stay day unit not fully resourced to provide adequate overnight care for patients. However, during periods of reduced flow through inpatient areas, staff used the unit to care for patients overnight. The senior team in unscheduled care was clearly aware of this and had implemented strategies to address it but this was not demonstrably matched by medical care services.
- We observed verbal abuse of emergency department staff and acute medical unit staff. Staff we spoke with described frequent situations in which the safety of staff had been jeopardised. This included patients using blood-borne infections as a biological weapon against

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staff and targeting of them in the local community when off-duty. Staff described a functioning relationship with local police but there was not an effective strategy in place to protect staff on site.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Effective governance systems to assess, monitor and improve quality and to mitigate risks to health, safety and welfare were not always functioning:** • There was a lack of demonstrable leadership at a senior level to address the ineffective internal professional standards, which reduced patient flow to medical specialties. This was evident during the site ops/flow meeting during our inspection, which was in its infancy. The medical director had no demonstrable input into engaging with medical specialties to improve flow from the emergency department. • There was a lack of awareness from the senior leadership team when the emergency department was in a surge situation. The operational pressures escalations levels framework (OPEL) was in place but did not effectively result in improved care in the emergency department or an improved response to patient needs. • The senior divisional team had a fundamental lack of understanding of mental health care facilities and services. This had a significant impact on patients. For example, the divisional general manager told us patients who presented with a mental health issue would be accommodated in the mental health decision unit (MHDU) whilst awaiting treatment. However, the MHDU was operated by another provider and would not see patients until they had been assessed by the mental health liaison team (MHLT); also provided by another organisation. This resulted in patients spending extended periods of time in inappropriate facilities.

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- Senior divisional staff did not have continuous or consistent governance processes established with providers who were responsible for critical aspects of the care of ED patients:
  - Non-clinical staff responsible for streaming and GPs who often returned patients to the ED for more advanced treatment.
  - There was limited evidence of structured, formal communication between the trust and the providers of mental health services. This meant there was poor coordination of governance and risk management. Evidence of the effectiveness of broader trust communication strategies was limited during our inspection.
- We raised our concerns about poor inter-organisational governance following the inspection but these were not acted on and immediate action to address the issues were not taken. This reflected a lack of oversight and understanding by the senior divisional team of key governance issues.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not always enough suitably qualified, competent, skilled and experienced staff deployed to meet patient need:** • There were no consultants trained in paediatric care in the department and overnight only one paediatric nurse in the department. This was against national best practice guidance set by the Royal College of Paediatrics and Child Health (RCPCH). • Overnight one specialist registrar led medical care in the ED and provided an on-call service to medical inpatient wards, including the acute medical unit. This workload was unmanageable and meant doctors routinely worked for over 12 hours without a break. • Senior medical staffing levels in the ED were not adequate to meet demand. A team of 13 whole time equivalent (WTE) consultants provided care from 8am to 10pm. This did not meet the Royal College of Emergency Medicine (RCEM) standard of a minimum of

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16 hours consultant cover per day. Only 2.5 whole time equivalent consultants were registered on the General Medical Council (GMC) Specialist Register, the rest were locum consultants. At weekends there was one consultant on duty from 8am to 1pm. This meant there was a lack of consistent senior medical cover in the department.