Mid Cheshire Hospitals NHS Foundation Trust

Quality Report

Leighton Hospital
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This report describes our judgement of the quality of care at this trust. 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 trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Mid Cheshire Hospitals NHS Foundation Trust as part of our new comprehensive inspection programme.

We carried out an announced inspection of Leighton Hospital between 8 and 10 October 2014. We also carried out an announced inspection of the Victoria Infirmary and Elmhurst Intermediate Care Centre on 9 October 2014.

In addition, an unannounced inspection was carried out between 5pm and 8.30pm on 24 October 2014 at Leighton Hospital The purpose of the unannounced inspection was to look at the management of medical admissions out of hours.

Overall, we rated this trust as 'good' and we noted some outstanding practice and innovation. However, improvements were needed to ensure that services were responsive to people's needs.

Our key findings were as follows:

Access and patient flow

Bed occupancy for the trust was consistently above 90% and worse than the England average. It is generally accepted that the quality of patient care and how well hospitals perform start to be affected when occupancy rates rise above 85%.

The trust was under significant pressure from high numbers of emergency admissions, which meant that some patients were not seen in the Emergency Department within the national target of four hours. The pressures on the number of available beds, particularly in the medical care wards, meant that once assessed patients could wait for extended periods of time to be seen by a specialist doctor. In addition, the lack of available beds meant that patients were often placed in areas that were not best suited to their needs (outliers). Patients also spent long periods in the Primary Assessment Area (PAA). This area was not a suitable environment for patients to be cared in the medium term. However, there were occasions when patients had remained in this area for up to three days. During our unannounced inspection we found the trust had implemented the 'Golden Patient' initiative to ensure that patients did not spend more than 24 hours in this area and were moved to a setting more suited to their needs at the earliest opportunity.

Surgical patients were also affected because operations were cancelled if intensive or inpatient beds were not available.

We also found that patients were in hospital longer than they needed to be and that patient discharges were not always managed in a timely way.

Delays in discharge were made worse by delays in securing community-based care packages. Although the trust was well aware of its challenges and was working on a solution, the required improvements were not yet visible at the time of our inspection. As a result, the management of patient access and flow across the hospital was of immediate concern and remained a significant challenge for managers.

Cleanliness and infection prevention and control

Patients received their care in a clean and suitably maintained environment. There was a high standard of cleanliness throughout the trust. Staff were aware of current infection prevention and control guidelines and consistently applied them when delivering care to patients.

There was a good rate of compliance with hygiene audits across the trust.

From July 2013 to July 2014 the trust reported four cases of methicillin-resistant staphylococcus aureus (MRSA) in the last year. This was a small number of cases and the trust had performed better than the England average since April 2014. For the same period an average of 30 cases of C. difficile infections were reported. This was worse than the England average until April 2014, when the numbers fell and remained better than the England average. Incidents of reported methicillin-sensitive staphylococcus aureus (MSSA) infections were variable but were generally better than the England average.

Medical staffing

Summary of findings

Medical treatment was delivered by highly professional and committed medical staff. However, there were a number of consultant vacancies and this meant there was not always enough medical staff to provide timely treatment and review of patients, particularly out of hours.

The trust was working hard to recruit and retain consultants. It had a number of initiatives in place including cross-working with neighbouring trusts and recruiting medical staff from overseas. These initiatives were helping to address medical shortfalls. Nevertheless, the shortage of medical staff meant that patients sometimes waited for extended periods of time to be seen by a consultant.

The pressures on the medical workforce had also led to delays in discharge letters to GPs. There were also concerns about the quality and content of the discharge letters as they were of variable quality and clarity. The lack of clarity had the potential to lead to confusion about who was responsible for the ongoing care of patients. The trust had recognised this as an issue and had begun to pay medical staff overtime to reduce the backlog. However, there were a number of wards and departments that were still struggling to send out this important information in a timely way.

There was also a shortage of trainee doctors. This was being taken forward by the Medical Director with the regional training schools with a view to the trust being allocated a full complement of trainee doctors. This would alleviate pressures on the existing team and free up more senior colleagues so they could see patients quickly.

Nursing staff

Care and treatment was delivered by committed and caring nursing staff who worked well together for the benefit of patients.

Nurse staffing levels were calculated using a recognised dependency tool. Although we found that staffing levels were appropriate at the time of our inspection, the trust was aware there was limited flexibility in nursing numbers to cope with increased demand or short notice sickness and absence. In response, the trust had worked hard to increase nursing capacity and had been successful in securing nursing staff from overseas. This initiative was seen very positively by the trust's nursing team, who had made their new colleagues very welcome. This active approach to nurse recruitment was ongoing at the time of our inspection. However, nurse staffing on the critical care unit did not always meet best practice requirements.

In maternity services, we found that the midwife to birth ratio was better than the England average.

Mortality rates

The trust showed insight in understanding the mortality data and identifying any potential improvement areas for patient safety or the patient pathway. In addition, work had been undertaken with the coding team and the medical staff to improve the coding information. Changes in coding practice had been made and the trust was confident that its mortality data quality had improved and would continue to do so.

Mortality and morbidity meetings were held weekly and were attended by representatives from all teams within the relevant divisions. As part of these meetings attendees reviewed the notes for every patient who had died in the hospital within the previous week. Any learning identified was shared and applied.

While we were carrying out our inspection the latest SHMI data became available. This indicated that the trust was moving nearer to expected levels at 104, continuing the positive downward trend. The trust stated its intention to remain proactive and vigilant in understanding and improving its mortality rates.

Incident reporting and investigation

The trust had a robust system for reporting incidents and near misses. Staff were confident and competent in reporting incidents and were supported by their managers to do so. The trust reported 4 never events during 2013/14. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.)

All never events had been subject to Root Cause Analysis (RCA) investigations and included a concise timeline and evidence of using recognised root cause analysis tools. There was good evidence of shared learning following RCAs and robust monitoring of recommended actions.

Safeguarding

Summary of findings

Safeguarding policies and procedures were available on the trust's intranet for both vulnerable adults and children. Safeguarding was supported by staff training and we found evidence of appropriate adult safeguarding referrals in line with trust policy and expected practice. However, there were some examples where the policy for safeguarding children was not followed appropriately. This included not seeking advice from the named doctor and not completing a body map when bruising was identified. In terms of safeguarding children, we also found that investigation findings were not shared widely and that opportunities for learning had been lost as a result.

Nutrition and hydration

Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs were supported by dieticians and the speech and language therapy team. Overall patients were complimentary about the quality of food that was served.

There was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help. There was a coloured tray system in place so that patients who needed assistance with eating and drinking could be easily identified and offered appropriate and discreet support.

Medicines management

Medicines were provided, stored and administered in a safe and timely way.

Anticipatory end of life care medication was appropriately prescribed for patients at the end of life. This was good practice as it enabled community nurses to give symptomatic relief without delay from the time the patient arrived home and helped avoid unnecessary readmissions to hospital.

We saw several areas of outstanding practice including:

- In medical care, the trust had introduced an electronic handover tool (e-handover) for which they had received a Health Service Journal Award. Medical staff at the trust had developed documentation for the care of patients on an alcohol detox pathway.
- The new critical care unit had been designed in accordance with the latest best practice guidance with the aim of reducing delirium and the problems associated with sensory deprivation. For example the rooms on one side of the unit benefitted from full length windows incorporating an electronic blind so that natural light was visible. In addition the unit made use of sky ceiling photo panels above patient beds, which displayed realistic images of blue skies, white clouds and blossom trees.
- The end of life care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medication.
- The hospital had a rapid discharge pathway to enable patients to be discharged from the acute hospital to home in the last hours /days of their lives. An audit in March 2014 showed that the preferred place of care (PPC) was achieved for 84% of patients seen by the specialist palliative care team (SPCT) and PPC wishes were met for 96% of the patients seen by the team.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times including and out of hours.
- Ensure that medical staffing is appropriate at all times including medical trainees, long-term locums, middle-grade doctors and consultants.
- Improve patient flow throughout the hospital to reduce the number of patient bed moves and patients' length of stay – particularly in the medical division.
- Take action to clear the backlog of discharge letters and implement an effective system for managing discharge letters so that GPs receive accurate and robust information about their patients in a timely way
- Ensure that escalation areas are appropriate environments for the care of patients and provide them with ready access to bathing and toilet facilities.

In addition the trust should:

Summary of findings

- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.
- Ensure that where patients are deemed not to have capacity to consent, staff are establishing and acting in accordance with the best interests of the patient and that this is appropriately documented.

In emergency & urgent care services:

- Ensure that all staff completed their mandatory training in a timely manner.
- Consider updating the sudden death checklist for paediatrics to include a "do not leave child alone with parents" step.
- Ensure they have a list of appropriate staff that have been trained with the required scene safety and awareness training.

In medical care services:

- Ensure timely access to treatment for upper gastrointestinal bleeds and stroke thrombolysis, including out of hours.
- Ensure action is taken to improve outcomes for patients with diabetes or who have had a stroke.

In surgery services:

- Ensure that appropriate action is taken to reduce the number of elective surgical patients that are readmitted to hospital following discharge.
- Continue to monitor and fully implement the proposed actions in order to reduce the number of cancelled operations and improve theatre utilisation.

In maternity & gynaecology services:

- Review and improve the provision of consultant anaesthetic sessions for elective caesarean sections to provide a more responsive service for women.

In services for children & young people:

- Consider reviewing safeguarding children training to ensure that the format, content and duration is in line with best practice guidance, in particular the provision of inter-agency training and that the time allowed for level 3 training is appropriate to support the learning needs of staff
- Ensure that safeguarding concerns are reported via the incident reporting systems to make sure that incidents are fully investigated and provide assurance that all relevant staff are aware of lessons learned.

In outpatients and diagnostic imaging services:

- The trust should take action to ensure that waiting times for outpatient clinics are improved and that clinics do not over run leading to cancellation of appointments.

At Elmhurst Intermediate Care Centre:

- Ensure that soiled linens are stored in a secure and appropriate manner.
- Ensure there are clear plans in place to address and manage identified risks. In particular the trust should ensure that outstanding portable appliance testing is completed.
- Ensure there are robust processes in place for staff to receive "lessons learned" feedback from incidents.
- Consider providing all staff with appropriate dementia care training.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Mid Cheshire Hospitals NHS Foundation Trust

Mid Cheshire Hospitals NHS Foundation Trust has three locations: Leighton Hospital, the Victoria Infirmary and Elmhurst Intermediate Care Centre. The trust provides a full range of hospital services at Leighton Hospital, including emergency department, critical care, coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, paediatrics and midwifery-led maternity care. The trust also provides outpatient services and a minor injuries unit at the Victoria Infirmary and intermediate care services at Elmhurst Intermediate Care Centre. In total the trust has 582 hospital beds.

The trust serves a local population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford. The health of people across Cheshire East, Cheshire West and Chester varies. Life expectancy for both men and women is better than the England average. However the local health profiles show Cheshire East has three indicators for children and young people that are worse than expected for smoking in pregnancy, starting breast feeding and alcohol specific hospital stays for those under18 years old.

The trust was rated as band 2 in the July 2014 update of CQC's Intelligent Monitoring Tool. Three risks and four elevated risks were identified. The elevated risks included: Summary Hospital level Mortality Indicators (SHMI); Hospital Standardised Mortality Ratio (HMSR) indicators (October 2012 to September 2013); Sentinel Stroke Audit Performance domain 2 – Overall team-centred rating score for key stroke indicators (October 2013 to December 2013) and quality of trust data returns (April 2013 to February 2014)

Our inspection team

Our inspection team was led by:

Chair: Dr. Nick Bishop MB BS MRCS FRCR FRCP, Senior Medical Advisor, Care Quality Commission

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, eight CQC inspectors and a variety of specialists including: Director of Improvement, Quality and Nursing, Trust Secretary, Quality Governance and Risk Management Specialist, Designated Lead Nurse for Safeguarding Children, Renal Physician, Consultant in Clinical Oncology, Surgeon (general surgery), Consultant Obstetrician and Gynaecologist, Consultant Anaesthetist, Trainee Doctor (general medicine/care of the elderly), Registered General Nurse, Paediatric Palliative Care Consultant Nurse, Nurse Clinician (surgical care services), Accident and Emergency Nurse, Head of Midwifery and Supervisor of Midwives, Critical Care Nurse, Nurse Practitioner, third year Student Nurse (general medicine).

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before our inspection we reviewed a wide range of information about Mid Cheshire Hospitals NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the

Summary of findings

Clinical Commissioning Group (CCG), NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

We held a listening event in Crewe on 6 October 2014 where members of the public shared their views and experiences of Leighton Hospital, the Victoria Infirmary and Elmhurst Intermediate Care Centre. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection of Leighton Hospital took place from 7 to 10 October 2014. We also carried out an announced inspection at the Victoria Infirmary and Elmhurst Intermediate Care Centre on 9 October 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection between 5pm and 8.30pm on 24 October 2014 at Leighton Hospital. The purpose of our unannounced inspection was to look at the management of medical admissions out of hours.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Leighton Hospital.

What people who use the trust's services say

Family & Friends test response rates were better than the England average 60% for July 2014 and indicated that most patients would be very likely or likely to recommend the Trust as a place to have care and treatment.

The trust had a total of 244 reviews on NHS Choices and the overall rating for the trust was 4.5 stars.

The CQC inpatient survey was conducted between September 2013 and January 2014. A questionnaire was sent to 850 recent inpatients. Responses were received from 442 patients. The trust was average when compared against similar trusts. It was noted that people rated waiting for a bed at the lower end of the scale.

Facts and data about this trust

Mid Cheshire Hospitals NHS Foundation Trust has three locations: Leighton Hospital, the Victoria Infirmary and Elmhurst Intermediate Care Centre. The trust has 582 beds in total.

In 2013/14 there were 29,404 admissions; 255,834 outpatients and 82,140 emergency department attendances. The trust employs 3,200 members of staff.

The trust serves a local population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford.

In 2013/14 the trust had a total income of £183.3m

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? The trust had effective arrangements in place for reporting safety incidents and allegations of abuse. Staff at all levels could describe their role in the reporting process and were encouraged to report incidents and concerns promptly. Staff were provided with feedback and learning from incidents was applied to prevent reoccurrence. Risks to patients were assessed, managed and monitored at all times and plans were in place to respond to emergencies and major incidents. All environments were clean and well maintained, although the outpatients department looked tired in terms of décor and seating. MRSA and C. Diff infection rates were better than the England average. Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. There was high compliance with hygiene audits throughout the trust. Staffing levels were planned, implemented and reviewed to keep the wards appropriately staffed to meet patients' needs. However there were some pressures in medical staffing numbers, particularly out of hours, that the trust was working to address.	Good
Are services at this trust effective? Care and treatment was delivered in accordance with evidenced based practice and national guidance. There was evidence of clinical audit being undertaken in all areas of the trust. The trust participated in 84% of the national audits it was eligible to participate in during 2013/14. There was evidence of learning from audits at ward and division level. There were monthly Quality Improvement Days to allow audit findings and recommendations to be shared with multidisciplinary teams to secure service improvement. Surgical services provided effective care and treatment based on evidence-based practice and national clinical guidelines and staff used care pathways appropriately. However, our inspection found that particular improvements were needed in medicine relating to the management of patients with diabetes and those who had had a stroke. There were also gaps in the provision of some out-of-hours services for patients with upper gastrointestinal (GI) bleeds and in providing thrombolysis for patients that had suffered a stroke. Multidisciplinary working was well established throughout the trust. Doctors, nurses and allied health professionals worked well together	Good

Summary of findings

to provide a holistic approach to patients' care and treatment. The sharing of information across the disciplines was, in the main, well managed. Each discipline listened and valued the contribution of their colleagues.

Staff had a good understanding of trust policies and procedures related to consent. Staff also understood the implications of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs). Staff were familiar with and adhered to, national guidance in seeking and supporting consent from children and young people.

Are services at this trust caring?

Good

All services were delivered by caring and commited staff. We observed staff treating patients in a kind and sensitive manner.Patients told us they were happy with the level of care they had received and that staff had treated them with dignity and respect.

A review of the friends and family data showed that most responses were positive, with most patients 'likely' or 'extremely likely' to recommend the wards and departments as a good place to receive care and treatment .Staff involved patients and those close to them in decisions about their care and their choices and preferences were valued by staff.

There were systems in place to offer emotional support to people if required, which was carried out with sensitivity and compassion.

Are services at this trust responsive?

Requires improvement

We found that staff were responsive to patients' needs through effective communication and sensitive, safe handovers of information. There were specialist support teams in the emergency department for those with alcohol or substance abuse-related conditions.

Good systems were in place to ensure that services were able to meet the individual needs of people, such as those living with dementia and those who had a learning disability or physical disability. Translation and interpretation services, and support for patients with other communication difficulties were available.

The trust had a rapid discharge pathway to enable patients to be discharged from the acute hospital to home in the last hours /days of their lives. An audit in March 2014 showed that the preferred place of care (PPC) was achieved for 84% of patients seen by the specialist palliative care team (SPCT) and PPC wishes were met for 96% of the patients seen by the team.

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However, bed occupancy for the trust was consistently above 90%, which is worse than the England average. It is generally accepted that the quality of patient care and how well hospitals perform begin to be affected when occupancy rates rise above 85%. The high demand for beds meant that patients often waited a long time to be placed in a clinical area best suited to their needs.There were significant numbers of patients accommodated outside the relevant specialty and patients sometimes experienced multiple moves between wards.

Surgical patients were also affected because operations were sometimes cancelled if intensive or inpatient beds were not available.

Patients were often in hospital for longer than they needed to be. The trust had recognised this as a problem and had implemented a number of internal processes to assist with timely discharge and increased bed availability. In addition the trust was working with its partners to ensure the prompt delivery of community based services so that patients could return home in a timely way.However some patients remained in hospital when ready for discharge.

The organisation of the outpatient departments at both Leighton Hospital and the Victoria Infirmary was not always responsive to patients' needs. Some clinics frequently over-ran and some patients experienced long delays in their appointment time. Clinics were sometimes cancelled at short notice which meant patients had appointments cancelled and re-scheduled.

At the time of our inspection there was no out of hour's service available for patients presenting with an upper gastrointestinal (GI) bleed. This appeared as a risk on the trust risk register and we discussed this concern with the trust. We were told of a partnership arrangement with a neighbouring trust to provide this service. This arrangement was to commence on 30 November 2014 and we were advised that informally patients would be able to access this treatment pathway with immediate effect.

Thrombolysis was available 9.00am to 9.00pm Monday to Friday. Outside of these hours, patients were transferred to adjacent acute hospitals if the time frame for administering thrombolysis could be achieved. We asked the trust for information on how frequently patients had been transferred for treatment but were told this data was not collated so it was not possible to establish the impact of the limited thrombolysis service on patients using the hospital.

Summary of findings

Are services at this trust well-led?

Good

There was an established executive team who were well known to staff. Directors were well informed and were regular visitors to ward and service areas. All staff we spoke with were positive about the visibility and accessability of the senior team

There was a clear link between the trust's values and its strategy. The trust had clear values that guided and supported positive staff behaviour towards people who used services.

Staff were committed and passionate about their work. Staff were open about the risks and challenges the organisation faced and understood the actions planned to address them. Staff were keen to learn and continuously improve the services they offered.

There was strong leadership, management and governance at trust level that supported organisational learning and staff development.

Overview of ratings

Our ratings for Leighton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Good	Good	Good	Requires improvement	Good	Good

Our ratings for Elmhurst ICC

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Mid Cheshire Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Requires improvement	Good	Good

Overview of ratings

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- In medical care, the trust had introduced an electronic handover tool (e-handover) for which they had received a Health Service Journal Award. Medical staff at the trust had developed documentation for the care of patients on an alcohol detox pathway.
- The new critical care unit had been designed in accordance with the latest best practice guidance with the aim of reducing delirium and the problems associated with sensory deprivation. For example the rooms on one side of the unit benefitted from full length windows incorporating an electronic blind so that natural light was visible. In addition the unit made use of sky ceiling photo panels above patient beds, which displayed realistic images of blue skies, white clouds and blossom trees.
- The end of life care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medication.
- The hospital had a rapid discharge pathway to enable patients to be discharged from the acute hospital to home in the last hours /days of their lives. An audit in March 2014 showed that the preferred place of care (PPC) was achieved for 84% of patients seen by the specialist palliative care team (SPCT) and PPC wishes were met for 96% of the patients seen by the team.

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times including and out of hours.
- Ensure that medical staffing is appropriate at all times including medical trainees, long-term locums, middle-grade doctors and consultants.
- Improve patient flow throughout the hospital to reduce the number of patient bed moves and patients' length of stay – particularly in the medical division.
- Take action to clear the backlog of discharge letters and implement an effective system for managing discharge letters so that GPs receive accurate and robust information about their patients in a timely way
- Ensure that escalation areas are appropriate environments for the care of patients and provide them with ready access to bathing and toilet facilities.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users. There was a shortage of medical staff within the medical and emergency care division, particularly in relation to trainee doctors and medical support out of hours. There was insufficient medical staff out of hours in the critical care services.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use the service are not always protected against the risk of receiving care or treatment that is inappropriate or unsafe because flow across the hospital meant that some patients could not be placed in the right bed at the right time for their needs. This led to extended length of stay and multiple bed moves. Some of the areas used for escalation beds did not provide an appropriate environment for the care of patients overnight. Discharge letters were not prepared and issued promptly leading to a possible delay in follow-up care and treatment for patients.