Stepping Hill Hospital

Poplar Grove
Stockport
Greater Manchester
SK2 7JE
Tel: 01614831010
www.stockport.nhs.uk

Date of inspection visit: 24 Aug to 25 Aug 2020
Date of publication: 27/10/2020

Ratings

Overall rating for this hospital	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Overall summary of services at Stepping Hill Hospital

Requires improvement

We inspected the urgent and emergency services at this trust on 24 and 25 August 2020 because we had issued a Warning Notice in March 2020. The warning notice followed an inspection in January and February 2020 where we had identified areas of significant improvement that the trust needed to make. This was a short-announced inspection focused inspection, so the trust was aware of our visit three days before the inspection. This was because of COVID-19 restrictions in the emergency department.

We did not rate services at this inspection. The ratings from the previous inspection remain.

Urgent and emergency services

Inadequate

Summary of this service

We did not rate the service at this inspection. Ratings from the previous inspection remain.

Stockport NHS Foundation Trust has an Urgent Care Village approach to the delivery of urgent and emergency care. The emergency department at Stepping Hill hospital provides care for all ages of patients attending with an urgent health problem either by self-presentation, ambulance or referral by a healthcare professional.

Patients are assessed and streamed to the most appropriate service for their needs (resuscitation, majors, psychiatry, minor injury, primary care or direct to a specialty in the case of healthcare professional referrals) in either an adult or paediatric setting within the same footprint.

The site is one of three designated trauma units in Greater Manchester (GM) working within a wider network to ensure the best care for major trauma patients for whom safe transfer to immediate treatment is paramount.

A local NHS mental health trust provides assessment for patients presenting to ED with urgent mental health needs; this provider has an offices and assessment space within the department.

The emergency department was divided into 'hot' and 'cold' emergency departments at the time of the inspection so that COVID-19 positive or patients suspected of COVID-19 were treated in the 'hot' side of the department with other patients treated in the 'cold' side of the department. There were resuscitation areas in both sides of the department.

We reviewed information and data before the inspection. During the inspection we spoke with 14 members of staff including senior managers, senior nursing staff, matrons, health care assistants, nursing staff, medical staff and staff from the local mental health NHS trust. We met with staff from the mental health NHS trust and the improvement manager from NHS England and NHS Improvement. We observed a patient flow meeting. We reviewed two completed mental health assessments on site and five patient safety checklists. We observed the care of patients in the department throughout the inspection. Following the inspection, we reviewed 10 mental health records and reviewed further evidence that we asked the trust to send to us.

We asked the trust to send out a survey to all staff in the department and 21 staff returned a completed survey to us.

Is the service safe?

Inadequate

We inspected safe but did not give a rating. The rating of inadequate from the previous inspection remains.

Our findings were

- The department had used a staffing tool to determine staffing levels in the department
- Recruitment of nursing staff was ongoing but all vacancies at band 6 and band 7 had been filled with a substantial reduction in vacancies at band 5.
- There had been recruitment of children's nurses to meet the national workforce staffing standards for children nurses.
- Safeguarding training levels had significantly improved for medical and nursing staff.
- Triage training rates and competency sign off had improved and further training was ongoing.

Urgent and emergency services

- The mental health assessment room had been refurbished and was compliant with National standards.
- A ligature assessment had been completed throughout the department.
- The department had introduced and were using a mental health assessment risk assessment tool. They had also introduced a standard operating procedure for patients presenting in mental health crisis.

However:

- The department was sometimes reliant on agency nursing staff which could impact the care and treatment of the patients in the department.
- There were some shifts that did not have two registered children's nurses.
- The timely completion of the patient safety checklist needed to embedded in departmental processes.
- Appropriate training for all nursing staff needed to be completed with competency sign off. This included triage training, aseptic non touch technique and plastering and suturing.

Is the service effective?

Requires improvement

We did not inspect effective. The rating of requires improvement from the previous inspection remains.

Is the service caring?

Requires improvement

We did not inspect caring. The rating of requires improvement from the previous inspection remains.

Is the service responsive?

Inadequate

We did not inspect responsive. The rating of inadequate from the previous inspection remains.

Is the service well-led?

Inadequate

We inspected well-led but did not give a rating. The rating of inadequate from the previous inspection remains.

Our findings were:

- Governance structures had improved so that quality, safety and risk were monitored in the department through a series of meetings and there were reports to the trust board.
- The department had an awareness of the main risks for the department at operational and strategic level in the trust, the risks were mitigated and reviewed.

Urgent and emergency services

- There was a memorandum of understanding to support partnership working between the trust and a local mental health NHS trust.
- Effective mental health governance structures were in place with a monthly partnership board and a mental health board every three months.
- There was ongoing work to support improvements to mental health services.
- Staff were involved in the change processes in the department so there was ownership of change. The trust had supported change management with support from the organisational development and the turnaround team.
- Staff were using the quality improvement methodology to develop and test the processes in the department. However
- The momentum of change needed to be maintained and embedded in the department so that change was sustainable in the medium and long term, particularly at times of additional pressure during winter.
- Flow through the department to the rest of the hospital should be monitored so that patients are not in the department for longer than necessary.

Detailed findings from this inspection

Is the service safe?

The warning notice stated that the emergency department did not have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment at all times, and particularly during periods of heavy demand on the service.

Staffing

Nurse staffing had improved since our inspection in January and February 2020 when we found the department did not have enough staff to keep patients safe from harm. Since this inspection the nursing establishment of the department had increased following an external review of staffing in the department and the use of the emergency department safer care nursing tool. At the time of this inspection all band seven and band six vacancies had been filled and there were now only five band five vacancies which was a significant improvement.. Recruitment was on-going, and two band five nurses had been appointed in the previous week. There were two health care assistant vacancies as two members of staff had been accepted for nurse training.

There were workforce meetings for the department every two weeks. Minutes of the meetings from 28 July 2020 and 10 August 2020 showed that staffing was being reviewed, that there was a workforce plan and a retention and wellbeing plan.

The current departmental changes to manage COVID-19 meant the department was divided into a ‘hot’ department and a ‘cold’ department for the cohorting of patients with confirmed symptoms of COVID-19. This required additional staffing of five nurses. Following some minor environmental changes to the department, the department could become one department again with appropriate measures in place for infection prevention and control, following the guidance from Public Health England. When this happened, the department would not require these additional staffing numbers and managers and staff told us that working as one department would be much more efficient.

The service was using agency nursing staff but as the department achieved full staffing and returned to one department it was envisaged that the reliance on agency staff would be substantially reduced. Staff told us that agency staff could slow down the flow of patients through the department as there were limitations to their practice, for example, administration of pain relief. A full-time pharmacist had been recruited to support the department.

The service had improved its provision of children's nurses. Our January/February 2020 showed that the staffing in the children's emergency department was not in line with the workforce standards in the Royal College of Paediatrics and Child Health's guidance document, "Facing the Future: Standards for children in emergency healthcare settings." which require every emergency department treating children to be staffed with two registered children's nurses. The trust had recruited additional paediatric staff and there were just over 10 whole time equivalent paediatric trained nursing staff in the department. The trust told us that compliance with the two trained paediatric staff was at 98% and that they tried to have a band six or band seven on each shift. There was an escalation pathway for paediatric staffing which included using staff from the children's ward. At the inspection in August 2020, nursing rotas showed that in the 69 days up to 2 July 2020 there were 10 shifts when staffing did not meet the minimum requirement for registered nurses.

There had been two incidents where there was only one children's nurse in the department at night. These were the 29 March 2020 and 25 April 2020 and patients had shown aggressive behaviour to staff who were lone workers in the department. There was no harm to the staff.

Due to the low numbers of children attending the hospital following the COVID-19 lockdown, the paediatric assessment unit was open 24 hours a day which meant that more seriously ill children and young people were taken directly to the unit. Staff reported that the wait for children and young people with minor presentations in the department could be lengthy.

Safeguarding

Safeguarding training completion had improved since our January and February inspection when we found safeguarding training levels were very low and significantly below trust targets. At the time of this inspection level one safeguarding training was at 100%, level two was 87.1% and level three was 85%. Additional training was booked for staff. Medical staff were 100% compliant with level three training. Consultants told us that the junior doctors training would also incorporate level three safeguarding training. In addition to this, senior staff had attended Multi-Agency Risk Assessment Conference training (MARAC) and Domestic Abuse, Stalking and Honour training (DASH). There would be a senior member of staff on each shift with DASH training who could complete appropriate assessments.

Staff told us that as a result of the safeguarding training, the quality of the safeguarding referrals had improved. A health visitor reviewed every attendance of children and young people aged 18 years and under on a weekly basis to identify any trends of attendance and any issues that might need to be followed up. Staff said that the safeguarding team would come down to the department if they were needed and that they were more confident with safeguarding processes.

Assessing and responding to patient risk

The trust's assessment of patient risks had improved since our January and February 2020 inspection when we observed patients with prolonged waits for pain relief and safety checks not completed in a timely manner. The department had improved their electronic patient safety checklist which was part of the patient record. The checklist included risk assessments such as falls, tissue viability and scores for pain and privacy and dignity and was completed on around 90% of patients attending the department as patients with minor injuries did not always require the completion of the checklist.

Staff had been involved in the ongoing development of the checklist and the questions were reviewed following staff feedback. Between April and July 2020 65-67% of checklists had been completed within 20 minutes of arrival, which was the target and 90% had been completed within an hour. In addition to improving completion rates we saw improvement in the information recorded about pain assessments, medicines, privacy and dignity and record keeping. Although some

areas were still not fully completed, such as catheter care, discharge and falls. Some of these were due to staff from outside the department not completing areas of the assessment. The department were aware of this and had an action plan to improve overall compliance. Compliance for completion of the checklist was audited every day and these results were fed back to the deputy chief nurse.

The service had improved training in triage. The inspection in January and February 2020 highlighted that registered nurses undertaking the role of triage nurses had not been trained in the use of the Manchester Triage guidelines. There had been no training for three years. Since the inspection this training had re-commenced. At the time of the inspection 19 staff had completed the course and had their competencies signed off and a further 20 staff had completed their training but had not had their competencies signed off. Four courses had been run with an additional course planned for October 2020. There was an audit of triage standards every month with compliance in May at 90%, June 91% and July 94%.

We saw improvement in training for aseptic non-touch technique with 84% of staff having completed the training and training for plastering and suturing training was planned for October. A member of staff had developed an induction pack for agency staff and new staff and another member of staff was developing a package to support student nurses. Staff were developing their competencies for non-invasive ventilation. We saw that staff records which showed when training had been completed and competencies signed off with certificates in their records. At the last inspection staff were unable to show the inspection team any evidence of completion of competencies.

Staff in the department were piloting new escalation processes for the deteriorating patient and they told us that they were using quality improvement methodology, including 'plan, do, study, act' cycles so that they could improve their processes.

The doctors had a huddle four times a day at 8am, 1pm, 5pm and 10pm. They exchanged information about patients to the lead consultant and highlighted any risks. The mental health liaison team would be part of these huddles if they were present in the department to update on any patients in their care.

We saw improvements for the risk assessment and treatment of patients with mental health ill-health. In our January and February 2020 inspection we had concerns that patients who presented at the emergency department with mental health needs were not cared for in line with national recommendations from the Royal College of Emergency Medicine (RCEM) guidance and Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services.

The trust had been working closely with the local mental health NHS trust and with an improvement manager from NHS England and NHS Improvement. At the previous inspection the mental health assessment room in the department was unsuitable for high risk patients. Improvements had been made and the room was now safe. The trust was also making improvements to the appearance of the room, including plans for vinyl pictures and a new door to give more privacy to patients in appropriate circumstances. There was agreed funding for an improved and safer paediatric assessment room and improvements to the toilets in the main department. A ligature risk assessment had been completed across the department.

Since the January and February 2020 inspection the department had introduced the mental health risk assessment tool. There was one for adults and one for children and young people under 16 years of age. There was a risk management standard operating procedure for patients who presented in the department in mental health crisis. The pathway risk assessed patients which then indicated the level of input and oversight. We also saw collaborative working with the mental health liaison team and the trust's safeguarding team.

In June and July 2020 the service had completed 100% of mental health assessments. Of those completed 67% were fully completed in June and 93% in July 2020.

Urgent and emergency services

We reviewed 10 patient records from mental health patients in the department as part of the inspection. Nine of the ten records showed that patients were triaged and reviewed within four hours, with times in the department of just over one hour to three hours forty minutes. One patient waited for five and a half hours in the department but was admitted to an acute psychiatric bed in the middle of the night and required transport to the mental health trust. They were triaged and reviewed in a timely manner.

There was a rolling programme of mental health training for staff in the emergency department provided by the local mental health NHS trust. A mental health aware passport had also been developed providing a knowledge framework to support the development of the staff in the department. Staff in the department were now part of cohorts that were assigned to a speciality and one of these was for mental health. This cohort were trained in mental health awareness provided by the local mental health NHS trust. There had also been recruitment of health care assistants with experience of working in mental health.

The department had introduced an observation check for the waiting room in the department. This was carried out every hour by a triage nurse. They could observe if patients were becoming agitated or needed pain medicine and try to address any issues. The nurse completed a record that the observations had taken place and we saw that this had been completed on the day of the inspection.

Is the service well-led?

The warning notice stated that there were ineffective governance systems to monitor quality, safety and risk across the emergency department. Without these patients were or maybe at risk of harm through the lack of identification of and subsequent review and mitigation of risk

Governance

We saw improvements in governance systems within the service since our January and February 2020 inspection. Since the inspection there had been strengthening of the leadership with an emergency department triumvirate appointed so that senior managers in the organisation could focus on improvements within the service. An improvement manager from NHS England and NHS Improvement had been appointed to support mental health services and the clinical director for quality and assurance was working exclusively in the department. There had also been changes to leaders within the department.

Staff told us that the pandemic had enabled them to “reset” the department. As there were lower numbers of patients, staff had time to complete training and to be involved in the operational development to make the improvements needed in the department following publication of the CQC report. There had been involvement from staff in the development of the mental health standard operating procedure. We saw that patients forums had been involved in mental health developments.

The service had a number of improvement workstreams including care of the escalating patient and staff had been involved in breach analysis and were using a surge tool to look at capacity and demand. We saw examples of how they had used quality improvement methodology, such as ‘plan, do, study, act’ cycles to review and make changes to processes.

The increase in staffing numbers and the changes in the nursing leadership had led to an improved patient safety culture in the department. Governance structures had been improved so that there was two-way feedback from staff to management about quality and safety in the department. The patient safety checklist audits were discussed at the staff meetings. Work on the checklists was ongoing. Staff had been given areas of development that they were interested in and so had ownership of these areas. Link nurses had also been identified for the department.

Urgent and emergency services

Following the appointment of a new lead nurse, there were now monthly sisters meetings that included the emergency nurse practitioners, where agenda items included staff development, recruitment, complaints, lessons learned, trends from incident reporting, compliments and reasons for breaching. There were meetings for all nursing staff in the department which were specific to their banding and feedback from these meetings fed into the sisters meetings.

There was an emergency department clinical governance meeting which was now held every month. There was representation from medical consultants, advanced care practitioners, the director of emergency medicines, senior nursing staff, the governance facilitator, and the business manager for the department. Agenda items included complaints, incidents, issues from the coroner, a nursing overview report, safety alerts, the departmental risk register and any serious incidents.

The service had an emergency department business group meeting with membership including the clinical director for the department, the associate medical director and the trust head of quality and governance. The meeting agenda focused on assurance and risk with agenda items including the nursing overview of the department, friends and family data, the quality improvement plan, incidents, information from inquests, morbidity and mortality reviews, learning from deaths and assurance compliance for the National Institute for Health and Care Excellence.

Since our January and February 2020 inspection the service had set up a monthly quality board for the department, with the first meeting on 13 May 2020. This was chaired by the clinical director for quality and assurance and had representation from board level directors and senior nurses and clinicians from the department. The terms of reference were reviewed at the first meeting to include the progress of the CQC action plan from the previous inspection. There was a focus on patient experience, patient quality and safety and governance. National and local audit data was discussed, and the meeting minutes showed that sepsis data and data from the national cardiac arrest audit were reviewed. The risk register for the department was an agenda item and we saw that changes were made to the risk register as a result of the meeting. The highest scoring risks at this meeting were insufficient nurse staffing, nurse shortages and the breaching of the four-hour operational standard for emergency departments.

We saw evidence of escalation of issues and performance through the trust governance structure which was an improvement. Progress against the improvement plans for the service were monitored through the committee structure through to the trust board. A report had been received by the trust board on 28 July 2020 of the CQC Improvement plan – the update and exception report, a more detailed report was due at the September board. The papers were also escalated to the health system wide improvement board which had been set up following our previous inspection.

Following the reconvening of the trust's quality and safety committee in August 2020 (which had been stood down due to COVID-19), the associate nurse director for the emergency department had submitted a report which included information on quality metrics, an update on patient safety checks, the mental capacity act, risks including staffing and flow and training. An emergency department quality dashboard had been developed to monitor patient safety and quality of care and this was reviewed by the trust patient safety quality board.

The frequency, membership and terms of reference of the meetings provided assurance that there were governance structures in place to monitor quality, safety and risk in the emergency department. However, many of the changes in the department needed to be embedded to ensure sustainability of the improvements. All staff we spoke with told us that they were concerned that this winter would bring challenges to the department and to the trust particularly around the flow of patients through the department and the hospital. We saw that wards had closed in the hospital due to COVID-19 outbreaks which had affected patient flow.

We saw improvement in the governance processes in relation to the care of patients with mental ill-health. A Memorandum of Understanding had been drafted with the local mental health NHS trust to enable effective joint

working which was ratified in July 2020. A mental health governance structure was set up for the two trusts. There was an adult emergency department mental health liaison meeting every week that fed into a mental health partnership forum along with the inpatient mental health liaison meeting. There would be input from the paediatric mental health liaison meeting, but this was not established at the time of the inspection.

The mental health partnership forum meetings were held every month, and these fed into mental health board meetings with executive sponsorship from the mental health trust and the acute trust. These meetings were held every three months.

The weekly meeting of the adult emergency department/mental health liaison was an operational meeting between staff from both trusts and was attended by local police. The agenda included incidents, serious incidents, complaints, risks and any breaches.

The improvement manager had developed an improvement bundle of key activities moving forward. Some of these included improvements on crisis pathways and a reduction in reliance on the acute trust for children and young people in crisis, alternative streams to the emergency department for people in mental health crisis and a reduction in high intensity use attendance rates to the department.

Managing Issues, Risk and Performance

Since the inspection in January and February 2020 we saw improvements in the trust's management of risk. We reviewed the risk register for the department. There were two risks that scored 20 which were the highest scoring risks for the department. These risks were, meeting the four-hour access target for emergency departments and insufficient nurse staffing for the department. The access target risk had been put on the risk register on 1 September 2017, there were mitigating actions against the risk and the next review date was 19 November 2020. The risk of insufficient nurse staffing was put on the register on 14 April 2020 and had a review date of 30 September 2020, there were mitigating actions against the risk.

We saw, from the minutes of meetings of the quality board meeting in May 2020 that risk was discussed and that the risk register was amended following the meeting. Senior staff we spoke were able to verbalise risk and describe the mitigation and review measures that had been put in place. Risk was discussed at departmental governance meetings so we were assured that senior staff and managers in the department and the trust could identify, review and mitigate the risk in the department.

Areas for improvement

The trust should :-

- Continue to reduce their reliance on agency staff in the emergency department.
- Ensure that every shift in the paediatric emergency department has two registered children's nurses.
- Continue to embed the patient safety checklist into the processes of the emergency department.
- Ensure that role specific training is completed for appropriate staff with competency sign off.
- Ensure that the momentum of change is embedded in the department particularly at times of additional pressure during winter.
- Ensure that all staff are fully engaged in departmental change.

Our inspection team

The inspection team comprised an inspector and a specialist advisor, who was a senior nurse from an acute trust with experience of working in and managing an emergency care department. The inspection was overseen by Judith Connor, Head of Hospitals in the North West.