Stockport NHS Foundation Trust

Stepping Hill Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Stepping Hill Hospital

Requires Improvement 

We only inspected urgent and emergency care during this inspection and we re-rated this core service.

As a result of re-rating this core service, the ratings for the hospital location changed slightly with the effective domain changing from requires improvement to good. The overall ratings for the hospital location and the trust overall remained the same at requires improvement.

We inspected the urgent and emergency care service on site at Stepping Hill Hospital on 1 and 2 November 2021 and we interviewed departmental leads on 4 November 2021.

This was an unannounced inspection (the trust did not know that we were coming) in order to re-rate the service following all action plans from a previous inspection being completed.

During the inspection we spoke to 33 staff members, three people who worked for other organisations, three patients, attended two meetings and checked 14 sets of patient records.

Urgent and emergency services

Good ↑↑

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- There were concerns about clinical oversight of patients in the waiting area and safety reviews of those patients. The trust responded to our concerns by adding additional triage support in the waiting area and improving the waiting area safety checklist. There was also a single ligature point in the mental health assessment room. The trust responded to our concerns by carrying out an immediate risk assessment and adding this to the risk register. They commenced a review to look at ways that the ligature point could be removed.
- The paediatric resus bay was also not visually or auditorily separated from the adult bays.
- The administration of antimicrobials for sepsis within one hour was not meeting trust targets and there were some omissions in the daily fridge temperature checks. There were audits in place to monitor both of these.
- There were some paper copies of patient pathways in use in the department that should have been accessed electronically to ensure that they were the most up to date copy. The trust responded to our concerns by removing paper copies of policies and pathways from the department.
- Although people could access the service when they needed it waiting times for treatment were not within national targets.

Urgent and emergency services

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and monitored the completion levels.

Staff received and kept up to date with their mandatory training. The expected compliance rate was 90%.

The mandatory training was comprehensive and met the needs of patients and staff.

Staff undertook online mandatory training in equality, diversity and human rights; fire safety; health, safety and welfare; infection prevention and control; information governance and data security; moving and handling; conflict resolution; basic PREVENT awareness and safeguarding Level 1 for children and adults.

We reviewed the mandatory training figures for nursing staff in the department and saw that in all but one of the courses, more than 90% of staff had completed the training. Figures showed that 81% of staff had completed the information, governance and data security course. Data showed that 100% of staff had completed the safeguarding courses.

We reviewed the mandatory training figures for medical staff in the department and saw that in all but one of the courses, more than 90% of medical staff had completed the training. Figures showed that 81% of staff had completed the information governance training. Data showed that 100% of medical staff had completed courses in equality, diversion and inclusion and fire safety. Medical staff were appraised against their training completion each year and this function was overseen by the medical director.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff in the department undertook life support training that was facilitated by the lead clinical practice educator. The trust had been unable to offer the full basic life support and immediate life support training courses throughout the COVID-19 pandemic. As an alternative, they had developed in-house, level two and three training courses in life support. Level two replicated basic life support training and level three training was somewhere between basic life support and immediate life support.

Nearly all band six and seven nurses already had advanced life support training that was still in date but needed to undertake the level three life support course on an annual basis as part of mandatory training. There was a plan in place to reintroduce immediate life support training for nurses from 2022 when training facilities were likely to be available again. At the time of our inspection, the education centre was being used as a vaccination hub.

Urgent and emergency services

Data showed that, at September 2021, 67% of eligible nurses had undertaken the level three life support training and 70% of eligible healthcare assistants had undertaken the level two life support course.

Nursing staff, advanced clinical practitioners and doctors in paediatrics were all trained in advanced paediatric life support.

We reviewed the life support training completion rates for medical staff of grade ST3 and above in the department. We saw that 89% had advanced life support training; 83% had advanced trauma life support training and 72% had advanced paediatric life support training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The patient record system prompted staff to consider the risk of safeguarding vulnerability and provided instructions should the risk be present. The patient record system alerted staff if an attending child was on the at risk register.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. An initial safeguarding review was completed for each patient at triage and if safeguarding risks were identified a referral to the multi-agency safeguarding and support hub (MASSH) at Stockport Council was made.

Training included PREVENT which is a part of the government's overall counter-terrorism strategy to reduce the threat from terrorism by stopping people becoming terrorists or supporting terrorism.

Training also included elements on female genital mutilation (FGM) and child sexual exploitation.

We reviewed the completion rates for nursing and medical staff for level two and level three children's and adults safeguarding courses.

We saw that 100% of nursing staff had received training in level two children's and adults safeguarding. Level three safeguarding children had been completed by 73% of nursing staff and level three safeguarding adults had been completed by 41% of nursing staff. These courses were repeated by staff every three years.

We saw that 100% of medical staff had completed the level two safeguarding children course and 92% had completed the level two safeguarding adults course. Level three safeguarding children had been completed by 74% of medical staff and level three safeguarding adults had been completed by 63% of medical staff.

Urgent and emergency services

Managers told us that the level three compliance figures were required over a three-year period but that the electronic system did not reflect staff who had begun the training and this was in progress. We were told that the emergency department had an action plan and improvement aim in order to ensure that there was a focus on completion of level three training.

The safeguarding team delivered face to face training for staff and had a timetable for training weekly. The team told us that two thirds of all staff in the emergency department were trained to level three in children and adult safeguarding. All on call doctors were trained to level three. There were also identified safeguarding leads in the department who were trained to level four.

Staff followed safe procedures for children visiting the department.

The trust safeguarding team had a strong presence in the department and visited regularly to speak to vulnerable patients who may need safeguarding.

The safeguarding team were developing an integrated model of working, building on perfect partnership working and introducing social workers into the emergency department to work with the discharge team and to strengthen the detection of vulnerable adults or children who may not be in the department but may be related to the patient.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The Patient-led assessment of the care environment (PLACE) last available scores are from 2019 and showed that the hospital had a 97.3% score for cleanliness. That means that 97.3% of people asked, said that the environment was clean. This was against an England average of 98.6%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact.

Measures to control and protect patients from infection, particularly from Covid-19, were in place in the main waiting room where screens had been installed between seats and some seats remained not in use to maintain social distancing as far as possible.

Patients who confirmed that they had a positive Covid-19 test at the front desk were diverted out of the department to enter via the ambulance entrance where they could be immediately isolated.

Environment and equipment

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

The designated mental health room within the department was appropriately furnished, lit and decorated. However, we did observe a keypad lock on a doorway from the room to a sluice room, which could have been used as a ligature point and there were potential blind spots, if patients were not monitored on a one to one basis. This was highlighted to the managers who took immediate action to risk assess the mental health room and look at potential solutions to remove the ligature point. Managers told us that patients were never left unattended in the room so that the ligature point and blind spots did not present a risk to patient safety.

The paediatric resus bay was not visually or auditorily separated from the adult bays.

Patients could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment.

Daily checks were in place for monitoring the safe and secure handling of medicines. Trust audit identified good overall compliance, except for fridge temperature monitoring. We found that the maximum and minimum temperatures were not always recorded in the fridge temperature records we sampled. The trust was aware about the gaps in recording fridge temperatures, having carried out audits.

The service had suitable facilities to meet the needs of patients' families. The paediatric emergency department was appropriate for the care and treatment of children and young people. It was separate from the main emergency department and there was a safe and secure waiting area for children and their families.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

We saw that the booking in clerk at main reception asked whether the patient was covid positive and if this was an affirmative answer, the patient was redirected to enter the department via the ambulance arrivals entrance where they could be isolated from other patients. However, patients with possible covid symptoms but no positive confirmation were mainly directed to the waiting room with all other patients by the navigator. There had been a policy previously to direct patients who may be covid positive to a “hot” area of the department, but hot and cold zones had now been stood down. We raised this and senior staff advised that they were acting in line with the most recent COVID-19 guidance.

Following our inspection, there was also an inspection of the department by the Health and Safety Executive who found that there were appropriate risk assessments and COVID-19 precautions in place.

We saw that there was limited clinical oversight of patients in the main waiting room. The navigator was employed by another provider and their role was to stream patients to the paediatric department, urgent treatment centre or into the waiting room to await triage by a nurse and transfer into majors or minors. Although the waiting room was next to the front desk, the navigator did not keep sight of the patients directed to wait in there. The triage room was off the main

waiting room and the triage nurse was generally occupied in a closed triage room. There was a waiting room safety checklist in place that was completed periodically by the triage nurse or support staff although we saw that this did not hold particularly meaningful information as there was a potential for relevant checks not to have been made and a lack of escalation pathways.

We escalated our concerns and were told that, when the waiting room was busy, they would often place a middle grade doctor in there to keep clinical oversight over patients and monitor patient pain relief needs and safety. We did not see a doctor in the waiting room. Following our concerns being raised the trust introduced a triage support nurse to the waiting area to support the triage nurse and keep clinical oversight of the waiting area.

The trust also immediately modified the waiting room checklist following a review of waiting room checklists at other trusts. The new checklist ensured that patients in the waiting area were escalated to the nurse in charge if there were treatment delays or had an elevated national early warning score (NEWS2).

We saw that there were comfort rounds in place in the waiting area to ensure that vulnerable patients and those living with diabetes had enough to eat and drink and had pain relief when necessary.

The triage nurse used the Manchester triage system to direct patients to majors or minors within the emergency department.

Patients complaining of chest pain were directed to several red chairs in the waiting room where they would be collected for an urgent ECG.

Staff completed risk assessments for each patient on arrival in the department, using recognised tools, and reviewed this regularly, including after any incident. The department had an 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. This was completed on around 90% of patients attending the department as patients with minor injuries did not always require the completion of the checklist. Analysis by the trust showed that 90% of safety checklists were completed within an hour of the patient's arrival and 62% within 20 minutes of the due time.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used a national early warning score (NEWS2) system for adults and a paediatric early warning score (PEWS) system for children to identify deteriorating patients. These systems scored a set of observations and prompted an appropriate response dependent on the score or whether the score was increasing.

Staff knew about and dealt with any specific risk issues. For example, for any patient presenting with a pressure ulcer, an incident was recorded, and tissue viability nurses assessed the patient where possible. Sepsis screening tools were in place and assessments for risk of falls or venous thromboembolisms. There was a sepsis trolley in the department so that sepsis treatment could be initiated quickly. The department had its own blood gas machine to support a prompt diagnosis. Risk assessments were used to record and act on risks of delirium (confusion).

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). An initial mental health assessment was made by the triage nurse who used a new mental health triage pathway.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Urgent and emergency services

Ambulance handover records showed that patients were being handed over and clinically assessed within around 15 minutes of arrival and ambulances were able to clear the department to attend another call within around 30 minutes. In the week ending 31 October 2021, the average ambulance turnaround time (time of arrival to clearing the site) was 30.04 minutes. On the day of our inspection the percentage of ambulance attendances that were taking 30-60 minutes to hand over was 3.5% against an England average of 13.5% and the percentage of ambulance attendances that were taking more than 60 minutes to hand over was 1.6% against an England average of 10.5%.

Ambulance crews told us that there were few delays in handing over patients when they arrived at the department and they did not have to hold patients in ambulances outside the department.

We saw limited corridor care. When patients needed to be moved to the corridor, at times of high demand, this was escalated to the lead nurse and an assessment made regarding which patients would have the lowest risk.

Staff shared key information to keep patients safe when handing over their care to others.

The lead consultant and nurse coordinator held overall responsibility for all patients in the department. 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.

Shift changes and handovers included all necessary key information to keep patients safe.

There was always a nurse in the department with advanced paediatric life support training. There was always a consultant in the hospital with advanced paediatric life support training who was either in the department or on call where this was not available.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The lead nurse could adjust staffing levels daily according to the needs of patients. There were two-weekly workforce planning meetings to plan nursing rosters well in advance. The department used the emergency care safer care nursing tool to plan staffing. The department had conducted workforce modelling and planning to meet the new increase in demand.

The planned numbers of nursing staff in the department were for 17 registered nurses on the early shift; 20 on the late shift; 21 on the twilight shift, dropping to 20 after midnight and 18 after 2am. There were seven planned healthcare assistants for each shift.

The number of nurses and healthcare assistants did not always match the planned numbers. We saw that there were short notice absences that meant that the numbers of nursing staff did not always meet the planned numbers, for example, we saw that on the first day of our inspection there were six nurses not able to undertake the late shift.

The trust did not always manage to fill all the nursing gaps but did make best use of bank staff and agency staff to fill gaps at short notice. There was a safer staffing meeting in the trust where nursing gaps were highlighted, and nursing staff were identified to move departments to provide cover. The meeting meant that gaps in late and night shifts were highlighted at an early stage so that solutions could be sought.

Staffing in the children's emergency department was 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. Nursing rotas showed that the paediatrics emergency department was always staffed by two registered paediatric nurses.

The paediatric emergency department had 11 whole time equivalent nurses (one band seven; four band six and six band five). There were vacancies for one band six and one band five nurse with interviews arranged for both posts.

The service had low vacancy rates. There was a rolling two-weekly programme of recruitment for nursing staff and the department could over-establish nursing staff to meet future plans for the department, such as the opening of a new clinical decision unit in December 2021.

The service had low turnover rates.

The service had low sickness rates.

The service had reducing rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The department had 13 whole time equivalent (WTE) substantive consultants. The department met the Royal College of Emergency Medicine standard of having at least one consultant in the department for 16 hours a day. Consultants worked in the department from 8am until midnight. The service always had a consultant on call during evenings and weekends.

There were two paediatric emergency medicine consultants in the department, though at the time of our inspection, one was on maternity leave.

The medical staff did not match the planned number for senior clinical fellows. The budget was for 20 WTE senior clinical fellows. At the time of our inspection 17 were in post. However, the locum budget allowed for 2.63 locum senior clinical fellows to meet planned staffing numbers. The department had conducted workforce modelling and planning to meet the new increase in demand.

Junior clinical fellows (junior doctors) were over-established by 4 WTE staff.

The total planned medical staffing was for 60 staff with 59.75 in post.

The service had low vacancy rates for medical staff.

The service had low turnover rates for medical staff.

Sickness rates for medical staff were low.

The service had low rates of bank and locum staff

Managers could access locums when they needed additional medical staff. There were a number of locum medical staff who had worked in the department for four to seven years and who were very familiar with the service. There were usually only one or two locum shifts per week.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was a roster review conducted by the lead consultant each Tuesday to ensure that there was adequate medical cover for the weekend and the following two weeks. Any gaps could be addressed and escalated in good time. There were few gaps in the medical rotas and managers told us that where there were gaps in junior doctor shifts, they would often be covered by middle-grade doctors.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The department used an electronic records system.

Patient notes were comprehensive, and all staff could access them easily.

We reviewed seven sets of adult patient notes and seven sets of paediatric patient notes and found these to be comprehensive and well completed. They were in line with trust and professional standards with risk assessments and allergies well recorded.

In the adult and paediatric patient notes we saw that the time of initial clinical assessment did not take place within 15 minutes in five out of the seven patients. However, in the paediatric notes three patients were assessed within 20 minutes.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had identified a risk related to using different electronic prescribing systems within ED on admission to hospital. The trust had put processes in place to help reduce the risk of errors, which was kept under review.

PGD's [Patient Group Directions] were used in triage to allow specified health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription from a prescriber.

Trust monitoring against standards for the administration of antimicrobials for sepsis within one hour reported only limited assurance: 82.4% (June 2021), 85.7% (Jul 2021) against a trust target of 95%. Performance was reviewed monthly, with action plans overseen by the patient safety group.

Weekday pharmacy support was provided with the specialist pharmacist and technician working as part of the multi-disciplinary team, focusing on medicines quality and safety. The pharmacy technician also supported medicines administration, focusing on patients taking critical medicines for example, medicines for people with Parkinson's disease.

Medicines related policy changes, incidents and alerts relevant to emergency department were reviewed by pharmacy in liaison with governance and nursing colleagues to identify learning and, shared through huddles. A protocol had recently been implemented for the use of inhaled pain-relief, reducing the need to use anaesthetic injections for injuries, such as a dislocated shoulder.

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

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Urgent and emergency services

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff used an electronic incident reporting system to report incidents. We saw that there was a strong incident reporting culture within the department.

The service analysed incidents and trends reported. From April to October 2021, a total of 841 incidents had been reported, an average of 120 per month. Of these, the highest reported incident category was pressure ulcers that were present on admission at 324 incidents (40.5% of the total), followed by behaviour of patients, 139 incidents (16.5%) and diagnostic processes, 54 incidents (6.4%).

The service had carried out further in-depth analysis of the behaviour incidents category and reported that 97 of the 139 incidents (70%) were due to missing patients.

The service had no never events during the last year. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

Managers shared learning with their staff about never events that happened elsewhere. Staff told us about an incident at another NHS trust that we were aware of that had led to changes in the mental health triage and assessment pathway.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was an emergency department serious incidents newsletter produced monthly to share the findings of recently closed investigations.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

There had been significant learning in the department in relation to aortic dissections following three serious incidents in the emergency department. A deep-dive into aortic dissections had been completed by the operational clinical director and presented to the team for learning.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Urgent and emergency services

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Pathways and policies were based on guidelines and standards set by organisations such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). The documents were easily accessible to all staff (including bank and agency staff) on the intranet.

However, we saw that there were some paper copies of pathways in the department. There was no review date on these policies. Managers told us that policies and pathways should only be accessed online as they were in date and they were unaware of the paper copies in the department. The paper copies were removed immediately as it was not clear whether they were the most up to date guidance.

There was also a paper copy of the British National Formulary in the department, but we saw that this was in date up to March 2022.

Expired policies and procedures could still be viewed on the trust intranet site, but users were warned that it had expired prior to opening and advised to check for a newer version or to contact the microsite administrator. All policies and procedures had an owner who held responsibility for updating the document. We were told that emergency department policies and procedures were reviewed and updated at the clinical effectiveness committee by staff from the department.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients who had been in the department for long periods were provided with hot meals.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Urgent and emergency services

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it, or they requested it. Patients told us that they had received pain relief when requested.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. There was a lead consultant for audits in the department. Submission to national audits had been halted during the COVID-19 pandemic, however, the department had continued to monitor outcomes against the national audit standards.

The service had participated in the Royal College of Emergency Medicine (RCEM) audits.

We saw that the department had scored highly against the national average in the standards for the RCEM audit on mental health (self-harm). An action plan was nevertheless in place to address gaps and make improvements to the scores achieved.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers and staff used the results to improve patients' outcomes.

In all standards in the RCEM audit on assessing cognitive impairment in older people the department scored poorly against the national average. We saw that the audit results had scrutiny and that an action plan with action owners and due dates to achieve the actions was in place.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

The service had a lower than expected risk of re-attendance than the England average.

Urgent and emergency services

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Newly qualified nurses in the department spent 12 weeks in the classroom and a supernumerary period of six weeks (newly qualified) or four weeks (qualified) when they started work in the department with a "buddy" to support them

Senior nursing staff worked on a rota system in the department as a supernumerary support to newly qualified and new staff. They were easily identifiable as they wore a purple uniform on shift.

Managers supported most staff to develop through yearly, constructive appraisals of their work. Data showed that at October 2021, 100% of eligible medical staff had received an appraisal. However, 30% of non-medical staff in the department had not received an appraisal. There were 53 overdue appraisals for non-medical staff at October 2021. The trust target for appraisal rates was 95%. The list of staff who had not received an appraisal was produced monthly for managers to book appraisals for them at the earliest opportunity.

The clinical educator supported the learning and development needs of staff. The department had a lead clinical practice educator who was responsible for facilitating training to all nursing staff and delivered some training to medical staff. They had carried out a full training needs analysis for the department. The department had a post out to advert for a band six clinical educator to support the lead clinical educator, at the time of our inspection.

There was a full programme of training for emergency department staff for 2022 already in place. This included a four-day induction training programme every two months for new staff. Other training included manual handling level two; trauma immediate life support; x-ray training; major incident training and paediatric emergency day training. Junior doctors were also invited to undertake any of these training sessions.

In addition, there were five or six training days per month delivered by staff in outpatients in wound care for healthcare assistants, suturing for nurses and plastering for all staff.

The department used the Royal College of Nursing competency framework to ensure that nursing staff were competent for their roles. When a competency had been observed and signed off by a more senior clinician, the competency could be applied to the nurse's profile.

Data showed that in October 2021, there were 164 eligible staff to undertake the competencies and the following competencies had been achieved: Aseptic non-touch technique (ANTT)(80%); administration of blood (93%); collection of blood (89%); female catheters (46%); male catheters (44%); medicines administration (74%) and physiological observations (95%). The emergency department had the highest levels of competency achievements within the trust.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff were able to dial into staff meetings from home if they wished.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff could spend a day training rather than perform an extra 12-hour clinical shift per month to make up their contractual hours.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Two band three healthcare assistants had been accepted to train as nursing associates and two band five nurses were undertaking a university course. Band two healthcare assistants undertook a care certificate qualification.

Many of the nurses working in the department had chosen to be link nurses and studied subjects in which they were interested, for example falls, infection prevention and control and tissue viability so that they could train other nurses in that subject or assist other nurses in caring for patients. There were also link nurses for international nurses, preceptorship and newly qualified nurses.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Handovers took place with nursing and medical staff three times a day to share information about the status of the department and address any issues. Staff were allocated to different areas of the department but supported each other and moved if one area was particularly busy.

Staff worked across health care disciplines and with other agencies when required to care for patients.

We observed that there was strong multidisciplinary working within the department with a lot of inreach from speciality teams to support patients entering the emergency department at the earliest opportunity.

The department was supported by nurses from the hyper-acute stroke unit who attended the department when a suspected stroke patient was arriving.

The frailty unit was located next to the emergency department and we saw that an occupational therapist and physiotherapist attended the emergency department to look at the frailty scores of patients in the department and they were able to make a diagnosis and arrange support for admission avoidance, without a referral from the emergency department.

Dietitians attended the department upon request. There were close links with the tissue viability nurses and there had been a lot of work around identifying non-hospital acquired pressure ulcers at an early stage so that they could be treated and the patient given the right support whilst in hospital and when they returned home.

We observed that the safeguarding team attended the department regularly to speak to any patients who had been identified as a potential safeguarding risk.

There was an alcohol liaison nurse in the department. Managers told us that they had made a great difference since starting work in the department in supporting frequent attenders and people with alcohol addiction. There were monthly multidisciplinary meetings to discuss frequent attenders to the department in order to get them the support they needed.

Urgent and emergency services

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. There was a strong working relationship between the staff in the emergency department and the mental health liaison team who worked for the local NHS mental health trust. The department had reviewed the mental health triage pathway and 100% of patients requiring a mental health assessment had them.

There was a weekly multi-agency mental health liaison meeting to monitor performance and to learn from and take actions from incidents.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, imaging and pharmacists, 24 hours a day, seven days a week.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support.

We saw there were leaflets available to patients in the department. There was plenty of literature on mental health conditions and support and patients could be signposted to alcohol or smoking cessation services as required.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Urgent and emergency services

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Urgent and emergency services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

The feedback from the urgent and emergency care survey 2020 was positive. The trust scored in the highest 20% of trusts in eight questions, including whether a member of staff explained the results of tests in a way that they could understand where they scored the highest nationally. They scored highly in other questions about communication and explanation of a patient's condition or treatment and privacy and dignity when examining a patient.

The department scored in the lowest 20% of trusts for two questions patients answered around being given enough privacy when discussing their condition with the receptionist and whether staff discussed their transport arrangements for leaving the department.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.

The department was adequately signposted so that patients could easily find it from outside or within the hospital.

Facilities and premises were appropriate for the services being delivered. The main waiting area of the department had sufficient seating and had screens in place between seats. There were several vending machines for the use of people in the waiting area.

Urgent and emergency services

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day. The same day emergency care (SDEC) unit was adjoined to the emergency department and the plans to redesign the department into an emergency care campus included plans to increase the capacity of the same day emergency care unit.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients living with dementia or learning disabilities were placed in cubicles in the central part of the majors department so that they could always be observed by staff.

The department was designed to meet the needs of patients living with dementia. We saw that the majors area of the department had introduced dementia friendly changes, including painting the department in calming colours, orientation boards, a dementia-friendly clock with the day, date and weather and an activity trolley to keep patients living with dementia and learning disabilities occupied whilst awaiting treatment. There were also dementia-friendly signs on patient toilet doors.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. We saw that there were picture cards available for staff to use as communication aids.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within four hours. However, this was an improving picture despite increasing numbers of patients coming into the service.

The Department of Health's standard for emergency departments is that 95% of patients should be assessed within 15 minutes of arrival in the emergency department. The trust was achieving around 50% of patients assessed within 15 minutes against this standard. However, they had undertaken a review of why they were not able to achieve this target and it was evident that patients who were navigated took seven or eight minutes longer to receive an assessment because the navigation process took 7.84 minutes on average and this was a constant. It was also evident that when the triage nurse had to complete safeguarding or mental health referrals, this slowed down the process for other patients. The trust was reviewing the role of the triage support nurse in the waiting area and believed that they could undertake roles that would reduce the waiting time to assessment for patients by three to four minutes.

Urgent and emergency services

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust achieved 64.6% compliance rate at the time of our inspection against an England average of 72.9%. For Type one A and E attendances this figure remained at 64.6% against an England average of 63.7%.

During the same week in 2020 the trust performance for all types of attendances was 57.16% so this showed an improving picture. Figures showed that the year to date performance was 71.53% on average.

At the time of inspection there had been eight 12-hour breaches (waiting more than 12 hours from decision to admit to admission) since 1 April 2021. Five of these were due to awaiting a mental health bed; two awaiting a Covid ward bed and one due to awaiting a specialist medical bed.

The percentage of type one attendances treated within 60 minutes of arrival into the department was 35.8% against an England average of 35.3% at the time of our inspection.

We saw that the trust had a consistently higher number of attendances that were majors than the England average and a consistently lower number of attendances that were minors patients than the England average.

The trust had conducted a 10-year review of numbers of attendances at the emergency department and it was evident that numbers had remained reasonably steady, rising slowly until the start of the pandemic when they dropped sharply. Since January 2021, the numbers of attendances had risen sharply to well above pre-pandemic levels and remained consistently high. The department had conducted workforce modelling and planning to meet the new increase in demand.

We saw that the short and long-term plans for the department had all been developed with the flow of patients through the department in mind.

Managers monitored waiting times and made sure patients could access services when needed and received treatment in a timely way.

Streaming into and through the emergency department began at the front door. Patients were seen by a receptionist who booked their details onto the records system.

There was a triage escalation process in place that used triage action cards so that additional support could be provided when the department and waiting area became busy. There were four levels in the escalation plan from green to black with clear actions that should be undertaken for each level and an identified lead.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw that there was constant monitoring of the patient dashboard, showing the number of patients in each part of the department so that concerns about increasing numbers of patients could be escalated at the earliest opportunity. There was a constant focus on ensuring that admittance and discharge was carried out as soon as possible.

There were several bed meetings each day. We observed one bed meeting and saw that there were clear messages about capacity within the hospital and the numbers of patients that needed to be admitted from the emergency department. There were clear messages about when patients would be discharged and good communication between

departments so that there was a clear picture of the overall situation. At the time of our inspection, bed capacity was at 95% and this was a steady situation. Despite, this, we saw that patients were moved out of the emergency department and admitted as soon as a bed became available. There was constant communication throughout the day with the emergency department to advise when a patient could be admitted with minimal delays.

The rapid assessment and treatment unit in the ambulance handover area had made a great difference to the times for ambulance handovers and minimised patients being held on the corridor awaiting assessment. Patients brought in by ambulance could be assessed within a relatively short period of time in one of a number of cubicles within the rapid assessment and treatment unit before being moved into the main emergency department area. Patients arriving by ambulance were very rarely held on a corridor. When a patient did have to be cared for on a corridor because there was no capacity, the department tried to move one of the more stable patients from majors who were awaiting discharge or admittance to the corridor, rather than a potentially unstable patient who had just arrived in the department.

The number of patients leaving the service before being seen for treatments was low.

Managers and staff worked to make sure that they started discharge planning as early as possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Urgent and emergency services

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good.

Leadership

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

The emergency department was a standalone division in the trust.

There was a triumvirate leadership team for the emergency department division with its own triumvirate leadership comprising nurse director, operational director and medical leadership with both a clinical director for strategy and assurance and a clinical director for operations. The emergency department was also supported by a lead nurse, consultant advanced clinical practitioner, and an associate director for operations.

At operational level in nursing, the service was led by the lead nurse, who was supported by two matrons and a unit manager. The trust had recently introduced a new role of chief registrar. The chief registrar supported junior and middle grade doctors in both medicine and emergency medicine services.

We saw that that senior leaders within the department were very visible within the department and they undertook clinical shifts. Staff reported that they were supportive and approachable.

Trust executives had visited the department to support staff and were able to describe the positive changes in the department. We attended a trust quality committee meeting before our inspection and saw that trust executives were keen to explore how they could further support staff in the emergency department during the expected winter pressures and were seeking the views of staff on this.

Leaders in the department had access to leadership training. Medical staff had access to leadership modules in their deanery training and the chief registrar led on engaging the medical workforce in leadership and decision-making. Junior doctors we spoke with told us they felt supported by senior colleagues.

The department had leaders for various specialisms, for example, there were lead consultants for paediatrics, trauma and mental health liaison. A matron was the lead for mental health and worked closely with the alcohol liaison specialist nurse. Advanced clinical practitioners and emergency nurse practitioners had lead roles in emergency planning and infection control.

The leadership team were well-sighted on the challenges and risks to the department and had worked cohesively to develop a comprehensive transformation programme for the emergency department. We saw that they had clear expectations of how other teams should support the emergency department in times of surge and that this was well-embedded.

Urgent and emergency services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a mission statement that was *"Making a difference every day".*

The trust had a strategy for 2020 to2025. The five key strategic objectives for the trust were defined in the strategy. These were:

- A great place to work
- Always learning, continually improving
- Helping people live their best lives
- Investing for the future by using our resources well
- Working with others for our patients and communities

We saw that the trust strategic objectives were displayed around the hospital and staff were aware of them.

The emergency department had developed a transformation programme called "achieving excellence" that was in line with the trust strategy. There was an achieving excellence board in the department and a service improvement group that was chaired by the chief executive in order to maintain executive oversight on the objectives.

The transformation programme had five workstreams, each with a nominated leader and clinical lead for oversight. The five workstreams and aims were:

- Initial assessment, navigation and triage. Aim: to improve the navigation and triage process and improve performance against the 15-minute standard.
- Clinical decision unit. Aim: to implement a clinical decision unit model of care in the emergency department.
- Urgent treatment centre. Aim: to implement an urgent treatment centre model of care in the emergency department.
- Mental health streaming and liaison. Aim: to implement a suitable location for mental health streaming and liaison within the emergency department footprint.
- Emergency department workforce review. Aim: to improve overnight performance through the appropriate and effective filling of medical rotas.

Each workstream had a number of objectives and monitoring measures. There was a plan on a page for each workstream and these showed that most of the objectives had been completed or were on track to be completed. Risks and issues for each workstream were clear in the plan, along with mitigating actions for each risk.

Staff had been involved in the development of the transformation programme through engagement events at which they could discuss priorities and things that they wanted to improve. Staff had been involved with the design of the proposed department rebuild. Staff had weekly meetings and a newsletter where they received feedback on the progress of objectives and plans.

Urgent and emergency services

In addition to the transformation programme workstreams, the trust also had a long-term plan for a rebuild and expansion of the emergency department into an emergency and urgent care campus by April 2024. The trust had been successful in a bid to receive £30.6 million public dividend capital that would enable them to uplift the internal floor area of the emergency department by 81% and improve access and flow in the department.

The proposed increase to the size of the department would allow for a further eight beds, two trolley spaces and four armchairs in a clinical decision unit; a further four trolley rooms in the resuscitation area; a further two assessment rooms, two consulting rooms and a safeguarding room in paediatrics; a further two assessment rooms and three fit to sit bays in the hyper-acute stroke unit; a further seven assessment rooms in the same day emergency care (SDEC) unit and a further three assessment rooms in a mental health area, including a room for young people.

The plan was well-developed, and the trust was on target to submit a full business case to NHS England/Improvement in April 2022.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they felt supported and valued. There was a commitment from managers to seek feedback from staff on how they felt working in the department and take suggestions for improvements.

We saw staff of all disciplines working well together and supporting each other within the department.

There were quick response (QR) codes in the department that staff could use to take them to an anonymous questionnaire where they could give feedback.

Managers told us that they had an open-door culture and we saw that they were in the department and asked after staff welfare. We saw managers covering for staff breaks when the department was particularly busy. The department provided snacks and drinks that were brought to staff during busy periods if was difficult to take a break

There was a strong emphasis on the safety and well-being of staff in the department. There were mental health first aiders available to staff in the department as well as a staff sanctuary room for staff to reflect in a quiet environment. The trust had also created a garden space for staff.

Staff had access to the Greater Manchester Resilience Hub where a range of support tools and a clinical psychologist were available to staff who could attend individual or group support sessions.

Managers told us that there was promotion of work life balance when arranging rosters and that there had been a big push on flexible working for staff, such as extended leave.

The department promoted equality and diversity. There were staff networks for LGBTQ+, disability and ethnic groups.

There was an international fellow doctor for the department to support overseas medical staff. There were also experienced supernumerary staff in the department who wore purple uniforms (“the purple shift”) to support less experienced staff.

Staff health and wellbeing measures brought in had led to an improvement in the staff engagement scores in the staff survey results, there were fewer vacancies and staff sickness had reduced.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance framework in place that enabled key messages to be communicated from the department to the board and vice versa.

The emergency department had a formal governance framework that fed into the wider trust governance framework. There were monthly clinical governance meetings (chaired by the operational clinical director), operational meetings (chaired by the operational manager) and a bi-weekly workforce nursing meeting (chaired by the operational manager and lead nurse). Key messages from these meetings fed into a monthly emergency department quality board that was chaired by the clinical director for strategy and assurance.

Leaders had a clear programme of meetings that took place on a monthly or bi-weekly basis. These included nursing meetings with senior nurses and band six and seven nurses, medical workforce meetings and a consultant senior team meeting. There were pathway meetings with the urgent treatment centre partners and an operational trauma meeting.

In addition, there were also regular meetings with stakeholders, such as the ambulance service and mental health liaison team. Leaders also represented the trust on the urgent care operational board for Greater Manchester.

The emergency department were represented as a division at key executive meetings to support escalation of concerns, informing the trust of risks, seeking approval for developments and changes and sharing performance metrics.

These meetings included the risk management committee that fed into the audit and risk committee; the patient safety, clinical effectiveness and patient experience groups that fed into the quality committee; the operational and capital programme groups that fed into the finance and performance committee and the people engagement and leadership group that fed into the people and performance committee. These committees in turn fed key messages and reports to the trust board.

Management of risk, issues and performance

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

There was an embedded culture of identifying, reporting and mitigating risks within the department. There was a departmental risk register in place. The risk register had review and completion dates. Risks and unclosed actions were reviewed at a weekly departmental meeting.

The medical director attended the risk committee where top risks were reviewed. The risk management committee reviewed all risks with a risk score greater than 10. This was chaired by the trust chief executive and presented oversight and challenge on how high risks were being managed.

Risks that scored above 15 and had a high risk rating were recorded on the trust significant risk register. There was only one risk for the department on the trust register. This was in relation to the department not meeting the four-hour access standard which could lead to delays in treatment and potential patient harm.

There were also 10 moderate risks and one low risk on a divisional risk register for the emergency department.

We saw that each risk had a risk manager and risk owner, there was a summary of controls in place, next review date and a series of action to mitigate the risk. We saw that most actions had been completed by the due date or sooner.

New risks were reviewed at the emergency department quality board and were monitored monthly at the quality board.

The emergency department underwent a monthly performance review with the executive team to review performance across a range of metrics, such as workforce, quality outcomes, finance and performance standards.

Leaders in the department were well-sighted on financial pressures that may compromise care. Workforce was the main financial pressure. A workforce review had been undertaken that had resulted in reduced locum spending and increased permanent staff. New roles, such as nursing associates had been introduced that had allowed the uplift of some band five nurses to band six. There was no cost improvement cap placed on the emergency department at the time of our inspection.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Data was collected using a performance dashboard to measure performance. Included in this were the time from arrival to treatment, overall time in the unit and outcome such as discharge, transferred or left without being seen.

The department had an electronic dashboard showing daily performance figures. This showed how many people were in the department in each area, waiting to be seen and how long each patient had been in the department.

There was an audio band system in the patient waiting area that could be used to deliver messages and waiting times to patients waiting in the waiting room. It could also be used to play calming music.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet.

Patient records were stored securely on an electronic patient record system. Patient safety checklists were also held electronically, which gave a more robust method of tracking the completion of safety checklists and the timescales in which they had been conducted.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patient feedback was actively sought using friends and family surveys. The local Healthwatch group spent time in the department on a regular basis to speak to patients and gather feedback.

The trust monitored compliments and complaints to identify areas for service improvement.

There was always a patient story used at the trust quality board, although this was not always an emergency department patient. This was either a positive or negative experience and was disseminated to staff for learning.

Service users had been engaged following feedback on services, to help improve patient pathways. The plan for the new department footprint had service user engagement factored in to ensure that the design and pathways met their needs.

There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade. Staff had been involved in designing the proposed new department.

The department had a staff star of the month and celebrated staff achievements.

There were notice boards around the department to inform staff about important topics such as mental health, learning disabilities, health and wellbeing and dignity and respect. We saw that the noticeboards were well used and contained a lot of useful information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We saw that individual staff were committed to continually learning and improving the environment for children and patients living with dementia, learning disabilities and mental health conditions.

There was support from the executive level of the organisation to drive improvements and empower managers to make decisions to deliver quality improvements.

We saw that there was momentum within the emergency department to deliver innovative restructuring of the service to improve access and flow and ensure that patients were treated at the right time by the right people.

Leaders were able to cite innovation and participation in research that the emergency departments had been involved in and of which they were proud. These included:

- the development of a tool for the criteria to admit patients. They planned to share best practice of its use with other organisations.
- the change in culture within the department and team working to drive improvements. Managers told us that the emergency department standards were owned by the trust rather than just the emergency department so there was a big team effort to move patients through the department and ensure that they received treatment in a timely way.
- the performance of the emergency department in the last year, meaning that they were in the top three performing departments within Greater Manchester.

- initiatives to reduce the time that patients spent in the department and the plans in place should further reduce this time.

Areas for improvement

MUSTS

Urgent and emergency Care

- The service must ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the department. Regulation12 (2) (a)

SHOULDS

Urgent and emergency care

- The trust should consider how the single ligature point in the mental health assessment room can be removed.
- The trust should consider how the paediatric resus bay can be further separated from the adult bays.
- The trust should consider how the omissions in fridge temperature recording, identified through audits, are promptly addressed.
- The trust should continue to monitor, audit and review the administration of antimicrobials for sepsis within one hour in order to meet the target of 95%.
- The trust should consider a further review of the direction of potentially COVID-19 positive patients (those without a confirmed positive test but displaying symptoms) at the point of entry.
- The trust should monitor, audit and review the use of additional triage support and clinical oversight in the waiting area.
- The trust should monitor, audit and review the use of the updated patient safety checklist in the waiting area.
- The trust should reinforce the message to staff that paper copies of patient policies and pathways should not be used in the department and remove any paper copies in use.

Our inspection team

The inspection team was made up of an inspection manager, a lead inspector, a team inspector, a medicines inspector and a specialist advisor.