Stockport NHS Foundation Trust

Stepping Hill Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	**Inadequate**
Medical care (including older people's care)	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Stepping Hill Hospital is the main location providing inpatient care as part of Stockport NHS Foundation Trust In total Stepping Hill Hospital has 833 inpatient beds.

We carried out an unannounced focussed inspection of Stepping Hill Hospital on the 21, 22 and 28 March 2017. We carried out this inspection to particularly look at the care and treatment received by patients in the Urgent and Emergency care department and patients receiving care from the Medical services team at the hospital.

We inspected these areas because of concerns identified at our announced inspection of the Trust in January 2016 and information received from other agencies during that time that indicated a lack of improvement in some areas

Overall, we rated Stepping Hill Hospital as Requires Improvement. We found that staff treated patients with dignity and respect, however this was at times compromised due to a shortage of nursing staff and patient safety was compromised. We requested immediate assurance from the trust to address the lack of nursing staff in the areas identified during the inspection to assure patients safety. The trust did respond to this and put a number of measures in place to address this in the short term. However these would not be sustainable in the medium or long term. The shortage of nursing staff and poor record keeping were identified as breaches in regulation at the last inspection, these issues still persisted in areas on both the emergency department and medical division. Improvements were needed to ensure that all services were safe, effective, caring well-led and responsive to people's needs.

We inspected the Urgent and Emergency care services and medical services in January 2016. Following this inspection we told the trust that they must take actions to make improvements to key areas including the safe delivery of care and treatment, nurse staffing, privacy and dignity, timely access to emergency and medical services and the management of patient records. When we returned for this inspection we found that the trust had not made sufficient or significant progress and improvement in a number of areas. Safety in the emergency department was still not a sufficient priority, nurse staffing was still a significant challenge and patients were still experiencing unacceptable delays in accessing care and treatment. In the medical services we found that access and flow remained a significant concern with the number of delayed transfers of care increasing by 30 per day since the last inspection.

We also found that in some areas the trust had deteriorated since our last inspection. In the emergency department we found that staff lacked an understanding of the Mental Capacity Act (2005) and consideration of this was evident in patient records. In the medical services we found that staff also lacked an understanding of the Mental Capacity Act (2005) and were not applying the deprivation if liberty safeguards appropriately. We also found that nurse staffing was below expected standards in the medical division and we observed occasions where this negatively impacted on patients safety.

Incidents

- All staff had access to the trust wide electronic incident reporting system.
- Staff were aware of what type of incidents they should report and were able to show us how they would report an incident.
- Some incidents were not investigated appropriately and associated action plans were not always up to date and meaningful. We also found that duty of candour was not always considered in a timely way.
- Staff told us that learning from incidents was disseminated through emails, communication files, newsletters and at daily meetings. However, a number of senior staff told us that when they incident reported staffing concerns they did not get feedback and the situation did not change.

Summary of findings

- We reviewed the summary of incidents for the 4916 incidents reported in the medical division. We noted inconsistency in the grading of incidents, for example a clostridium difficile (c.diff) infection was categorised as minor, moderate and major. We received the incident grading from the trust, which explained to all staff the appropriate grades for types of incident. However, we found several instances of deviation from this policy and no evidence of action taken as a result of this.
- The trust's incident grading criteria did not reflect across to general incident grading criteria used in other NHS organisations, for example the trust did not use no or low harm categorisation instead using 'minor' as a categorisation for low or no harm incidents. This left the trust open to mistakes in incident reporting categorisation particularly by bank and agency staff, which, at the time of our inspection, the trust heavily relied on.

Nurse Staffing

- Across both the Emergency and Medical services divisions there were significant shortfalls in nursing staff.
- During the inspection we saw examples of where this had impacted on the safety and quality of care patients received; for example
- In the Emergency and Urgent care department early warning scores (EWS) designed to identify patient who were deteriorating, were not completed in line with the trusts protocol in all cases we reviewed.
- We observed that trolleys and cubicles were not always cleaned between patients use and the sluice room was found in visibly soiled state.
- In the medical department staff were frequently moved from their usual area of practice to fill gaps in rotas. This resulted in staff being placed in areas where they felt they did not have the necessary skills and competence to meet the needs of patients.
- At the time of our inspection on ward A11, there were two nurses and three HCAs on duty, when there should have been three nurses and four HCAs. Two patients had left the ward without being observed, one of which was subject to a DoLs.
- Ward staff had taken appropriate action once they discovered the patients had left but steps had not been put in place to address the staffing issue until we escalated this to the trust.
- During our inspection, on all the wards that we visited there was one to two nurses less per shift than had been identified as required to meet patients' needs. A number of senior nursing staff told us that patient care was compromised when staff were taken away from the wards to support other areas. . On one ward during our inspection there was one registered nurse to 10.5 patients. On another ward, there was one registered nurse to 13 patients. Staff told us the impact on patient care is that falls assessments and risk assessments are not completed, as priority has to be given to direct patient care and the provision of medication.
- In the Emergency and Urgent care department shift fill rates varied across recent months but were consistently below 80%. In some cases the numbers of shifts unfilled by bank or agency staff exceeded 50%.
- In the medical services some areas including the coronary care shift fill rates were consistently below expected standards and at times were below 50%.

Medical Staffing

- There was a high rate of medical staff vacancies across the medical division and the turnover of medical staff was within the trust target.
- There were rotas in place which included medical trainees. There was an on call rota which ensured there was consultant cover 24 hours a day seven days a week. This meant that senior advice was available at all times. Nursing staff told us that they were able to access medical assistance and advice easily
- The number of consultants working at the trust was about the same as the England average but the number of junior doctors was lower than the England average.
- Medical staff morale was low in the emergency department with medical staff telling us that they felt they could not provide the level of care they wanted to due to capacity issues.

Summary of findings

- The general medical council had implemented enhanced monitoring of the trust medical staffing due to safety concerns raised by junior doctors in the emergency department.
- Medical staff told us that they felt the education program offered to them was not sufficient.

Mental capacity and deprivation of liberty safeguards (DoLS)

- Across both the emergency and medical services department's staff did not have a good understanding of the mental capacity act (2005) (MCA) and its application or the deprivation of liberty safeguards (DoLS).
- When speaking to the staff there was a limited understanding of the trusts own policy regarding MCA and DoLS.
- The application of both the MCA and DoLs at ward and department level was inconsistent and in the majority of cases we inspected records were unclear and incomplete.

Cleanliness, infection control and hygiene

- Staff were observed using personal protective equipment, such as gloves and aprons and changing this equipment between patient contacts and we saw staff washing their hands using the appropriate techniques.
- We saw that staff followed the 'bare arms below the elbow' guidance.
- There was adequate access to hand washing sinks and hand gels.
- Monthly infection control audits were undertaken across all wards and departments, which looked at standards such as the cleanliness of patient equipment and hand hygiene. We reviewed these infection prevention audits.
- The hand hygiene audit findings were below the trust's target of 90% compliance. These ranged from 68.8% to 79.4%
- The audit which looked at how well the infection control and prevention measures in relation to indwelling devices was managed ranged between 80% and 52% these were below the trust's target of 90% compliance
- Infection prevention and control staff training figures were 90% for level one training and 87% for level two training, which were both below the trust's target of 95%.
- Staff training in infection control in the emergency department was above the trusts 90% target.

Records

- The hospital used electronic and paper based patient records across the medicine division, only a very few paper records were used in the emergency department.
- During our last inspection we identified that the records trolleys that were inspected were unlocked which meant they were potentially accessible by members of the public.
- During this inspection across the emergency department electronic records were secure, restricted to authorised access and easily accessible to authorised staff. However paper records were not kept secure and were stored in pigeon holes which were accessible to members of the public.
- Across the medical division in all areas we visited, except A11, records trolleys were unlocked. Whilst the records trolleys were located at the front of nursing stations, we observed that these areas were not always manned therefore representing the same risk.
- Records audits were undertaken to review compliance with the trust's record policy.
- These audits showed a mixed rate of compliance across the six month period prior to our inspection.

Access and Flow

- There were high numbers of delayed transfers of care (patients who were medically fit to be discharged but remained in hospital) and these had increased significantly since the last inspection in January 2016. This was having an adverse impact on the medical division's ability to accommodate and care for patients safely and effectively.
- There had been a significant increase in the number of' black breaches' (Black breaches occur when the time from an ambulance's arrival to the patient being handed over to the department staff is greater than 60 minutes). Since the last inspection. During the last inspection we found that from November 2014 to October 2015 there were 199. During this inspection we found that in one month alone this figure had been exceeded and there were no months between January 2016 and January 2017 where less than 20 black breaches occurred.

Summary of findings

- We observed the department lacked capacity to accommodate patients and patients were routinely treated and accommodated in the corridor areas.
- There is a Department of Health standard for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival. From January 2016 to January 2017 the hospital did not meet this standard for all 12 months and the average percentage of patients admitted and transferred or discharged was 77.4%.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

In urgent and emergency services

- Ensure that all medications in the emergency department are securely stored at all times.
- Ensure that patients received their medications in timely manner and ensure that any necessary checks are completed in line with local and national guidance and policy in the emergency department.
- Ensure that patient records are accurate, up to date and reflect the care the patient receives in the emergency department.
- Ensure that all staff are up to date with their mandatory training in the emergency department. Specifically in relation to life support and safeguarding.
- Ensure that patients are protected from infections by isolating patients with suspected infections and cleaning areas where patients receive care in line with their infection control policies and procedures in the emergency department.
- Ensure that staff follow clinical guideline sand provide evidence based care.
- Ensure that patients risk is appropriately identified and all possible measures are taken to minimise risks to patients safety are in place. Specifically in relation to patients being accommodated in areas not designed for clinical care such as corridor areas.
- Ensure that patients are treated with dignity and compassion and that their dignity and privacy is maintained at all times while they are in the emergency department.
- Ensure that patients can access emergency care and treatment in a timely way.
- Ensure that all risks identified in relation to the emergency department are appropriately risk assessed and appropriate control measures are in place.

In medical services

- The trust must ensure that records are securely stored.
- The trust must ensure that patient risk assessments are completed and updated at regular intervals.
- The trust must ensure that it is compliant with the Mental Capacity Act and that all staff have the required level of training in this area.
- The trust must ensure that its mandatory training reporting systems are accurate and reflective of the training needs and requirements of all staff.
- The trust must ensure all staff are up to date with their mandatory training.
- The trust must ensure that at all times there is a suitably trained member of staff on each medical ward and unit that has current adult life support training.
- The trust must ensure there is consistent categorisation of the same type of incident in the trust's incident reporting system.
- The trust must ensure safeguarding training levels for staff are in accordance with the trust's own policy and best practice guidance.
- The trust must ensure there is an adequate skills mix on all medical wards and that staff have the right level of competence to effectively nurse the patients they are asked to care for.
- The trust must do all that is reasonably practicable to ensure there is safe staffing on the medical wards.
- The trust must address the delayed transfers of care and formulate an action plan outlining how it will address this issue within a reasonable time period.

Summary of findings

- The trust must ensure nursing intervention records are consistently completed.
- The trust must ensure that thickening powder is securely stored.
- The trust must ensure that patient's dignity is preserved at all times across the medicine division.

In addition the trust should:

- The trust should consider implementing clear guidance for senior staff to use when making judgments about staff moves.
- The trust should ensure that where audit findings fall below the trust's expected standards, action plans to address this are created and monitored.
- The trust should improve the appraisal rate for the medicine division.
- The trust should ensure the proportion of patients seen by a cancer nurse specialist is above audit minimum standard of 80% for lung cancer.
- The trust should ensure that patients' discharge summaries are published within 48 hours.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	We rated urgent care services as inadequate because: • Although we noted an improvement in the senior nurse leadership in the service and found a more open and positive culture there were still significant issues which persisted from the last inspection. • There was poor infection control compliance including patients not being isolated appropriately, visibly soiled equipment and less that 60% compliance with key audits. • Duty of candour was delayed in some cases. • There were low nurse staffing levels and low shift fill rates of less than 50% at times. This also included very high use of agency staff. • There was a low compliance with the early warning score system and poor management and recognition of sepsis. • Medicine management issues persisted which included lack of security and delayed administration. • We found poor compliance with risk assessment processes and patients were being held in corridors on routine basis. There had been no improvement to the arrangements to manage the patients held in the corridor area. We found that very unwell patients were being held there with very little or no supervision this included patients with cardiac issues and sepsis. • The performance in relation to the 15 minute face to face assessment, four hour standard and ambulance handovers remained very poor and had deteriorated since the last inspection. Black breaches had increased fivefold from 199 in 12 months in the last inspection to 218 in one month during this inspection. • Clinical guidelines were not always followed and we found occasions when this had negatively impacted on patient outcomes.

Summary of findings

- The department had undertaken one national audit since the last inspection and this showed that they were not complaint with all four standards looked at.
- Audit findings were not always actioned and action plans were not always monitored.
- Patients were left in an undignified manner in the corridor areas including having physical examination in the corridor areas. Some patients told us that they were humiliated by their treatment.
- Medical staff did not always feel supported and felt that their education and development program was not sufficient.
- The viewing room for deceased patients had not improved since the last inspection and remained visibly soiled and clinical.
- We found that deceased patient's property was not treated in a sensitive manner and we found bags of unlabelled property stacked up on the floor in the viewing room.
- We observed very poor record keeping which we saw negatively impact on patient care and safety, including staff being unaware that a patient had left the department until three hours later when inspection team noted this.
- There was routine overcrowding and the department consistently failed to meet the department of health standard of seeing, treating and discharging or transferring patients within four hours.
- Some risks were not identified or mitigated appropriately.
- Medical staff told us that concerns they raised were not listened to or acted on.

However:

- Staff were knowledgeable about how to manage safeguarding issues and we observed them acting on safeguarding concerns appropriately.
- Equipment was checked regularly and appeared to be in good working order.
- The paediatric department had improved their safety since the last inspection.

Summary of findings

- Staff told us that since the new matron and nurse consultant had been appointed, safety was more of a priority and focus.
- Staff spoke positively about the newly appointed matron and the changes she had implemented.
- Staff sought appropriate consent from patients before delivering treatment and care.
- The department had a team of highly skilled and competent nurse and medical staff.
- Appraisal rates were much improved from the last inspection.
- Staff were observed to be treating patients with compassion and dignity in their one to one interactions with patients.
- Some patients spoke positively about the way staff treated them.
- Staff were caring and compassionate in their approach to patient care.

Medical care (including older people's care)

Requires improvement

We rated this service as requires improvement because:

- The trust had not responded appropriately to the risk expressed to them at our last inspection regarding the security of patients' records.
- The trust regularly moved their own staff and had a heavy reliance on agency and bank staff, resulting in inappropriate skills mix and staff feeling they were nursing in wards where they did not have the required competence to care for patients.
- Decisions to move nursing staff were made on clinical judgment without a clear guidance document or minimum set standards.
- Records completion was not in accordance with best practice guidance.
- Incident reports did not have consistent categorisation for the same type of incident.
- Infection protection audits showed low levels of compliance with the trust's policy. At the time of reporting action plans to address this were not provided.
- Safeguarding training levels for staff were not in accordance with the trust's own policy or best practice guidance.
- There was a lack of consistency in how people's mental capacity was assessed and not all

Summary of findings

decision-making was informed or in line with guidance and legislation. Decision-makers did not always make decisions in the best interests of people who lack the mental capacity to make decisions for themselves, in accordance with legislation. Restraint and deprivation of liberty were not always recognised or less restrictive options used where possible. Applications to authorise a deprivation of liberty were not always made appropriately or in a timely manner to the Court of Protection or by using the Deprivation of Liberty Safeguards.

- Due to staffing pressures, patients' dignity was not consistently maintained.
- The arrangements for governance and performance management did not always operate effectively.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way. The risks and issues described by staff do not consistently correspond to those reported to and understood by leaders.
- In view of the expenditure for agency staffing, the sustainable delivery of quality care was put at risk by the financial challenge.

However:

- Staff understood their responsibility to report incidents.
- Staff were aware of the duty of candour and their obligations regarding this.
- All areas we inspected were visibly clean and tidy.
- Throughout our inspection, in most wards we visited, we did not identify any major environmental risks or hazards.
- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse.
- Medicine storage was secure and accurate logs and records maintained.
- Since the last inspection, the service had achieved JAG Accreditation for their endoscopy services.
- Patients' nutritional status and dietary needs were assessed using a recognised assessment tool.

Summary of findings

- Multidisciplinary team (MDT) working was established on the medical wards. We saw good examples of MDT working on all of the wards and units we visited.
- Staff offered kind and considerate care to patients and those close to them. We saw that for most patients, privacy and dignity was maintained and that most patients' needs were appropriately met. Patients and those close to them understood their treatment and the choices available to them.
- Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were sensitive and compassionate in supporting patients and those close to them during difficult and stressful periods.
- .In geriatric medicine, the service was above the England average for admitted RTT (percentage within 18 weeks).
- There was a clear statement of vision and values, driven by quality and safety. It had been translated into a credible strategy with well-defined objectives that were regularly reviewed to ensure that they remain achievable and relevant.
- The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others
- The trust's staff in all areas knew and understood the vision, values and strategic goals.

Stepping Hill Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care)

Detailed findings

Contents

Background to Stepping Hill Hospital

Stepping Hill Hospital is the main location providing inpatient care as part of Stockport NHS Foundation Trust. It provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

Stockport Foundation Trust provides services for around 350,000 people in and around the Stockport area with approximately 912 inpatient beds. In total, Stepping Hill Hospital has 833 inpatient beds.

During this inspection we inspected the accident and emergency department and medical care services at the hospital that provide care and treatment for a wide range of medical conditions, including general medicine, cardiology ,respiratory and gastroenterology and a specialist stroke centre serving the south of Greater Manchester. The hospital also provides surgical services, critical care services, maternity and gynaecology services, paediatric services, end of life care (EOLC) and a range of outpatient and diagnostic services which were not inspected as part of this inspection.

Our inspection team

Our inspection team was led by: **Inspection manager** Wendy Dixon, Care Quality Commission

The team consisted of an inspection manager three CQC inspectors and a variety of specialists, including a Consultant Physician, Clinical Nurse Specialist, Emergency Department nurse specialist and a senior Emergency Department doctor

How we carried out this inspection

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

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

Detailed findings

• Is it well-led?

The inspection team inspected the following core services at Stepping Hill Hospital:

- Urgent and Emergency Department
- Medical care (including care older people's care)

Following the unannounced inspection, we reviewed a range of information we held about the hospital and requested further data from the Trust. We talked with patients and interviewed staff from the ward areas and the accident and emergency department we visited. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Stepping Hill Hospital

Facts and data about Stepping Hill Hospital

Urgent and emergency services at Stepping Hill Hospital saw approximately 96,217 patients between January 2016 and January 2017. Approximately 32% of these patients were admitted to hospital, this was above the England average of 22.2%. The department is open 24 hours a day, seven days a week and provided treatment and care for children and adults. The department saw 21,147 children during this time period. There was a resuscitation area, examination rooms and a waiting area. There is also a self-contained children's area.

From March 2016 – February 2017 the trust had 89,659 medical admissions including day case admissions. 28,390 of these admissions were from the emergency department. This averaged 7,472 admissions per month and with the exception on November 2016, remained around that average figure month on month.

There are a total of 833 beds at the hospital and serves a population of 350,000 people.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	N/A	N/A	N/A	N/A	Requires improvement

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided at Stepping Hill Hospital. The Emergency Department (ED) at Stepping Hospital is open 24 hours a day, seven days a week, providing emergency and urgent care and treatment for children and adults, across Stockport and wider Manchester area.

The department saw approximately 21,147 patients between January 2016 and January 2017. Approximately 32% of these patients were admitted to hospital, this was above the England average of 22.2%.

The Emergency Department consists of a four trolley resuscitation area, 19 major's trolleys, a three cubicle hyper acute stroke area, one sub-wait area and four examination rooms.

There is a self-contained children's ED (consisting of 3 cubicles) and a minor's stream which is run by enhanced nurse practitioners seven days a week between 07:30am - 00:00am.

As part of our inspection we visited the emergency department for an unannounced inspection on 21, 22 and 28 March 2017. We spoke with patients and relatives, observed care and treatment and reviewed 18 records, including observation charts, medication charts and full care records. We spoke with a range of staff at different grades including nurses, doctors, health care assistants, reception staff, ambulance staff, senior managers and matrons.

Summary of findings

We rated urgent care services as inadequate because:

- Although we noted an improvement in the matron level of leadership in the service and found a more open and positive culture there were still significant issues which persisted from the last inspection and safety remained not a sufficient priority.
- There was poor infection control compliance including patients not being isolated appropriately, visibly soiled equipment and less that 60% compliance with key audits.
- Duty of candour was delayed in some cases.
- There were low nurse staffing levels and low shift fill rates of less than 50% at times. This also included very high use of agency staff.
- There was a low compliance with the early warning score system and very poor management and recognition of sepsis.
- Medicine management issues persisted which included lack of security and delayed administration.
- We found poor compliance with risk assessment processes and patients were being held in corridors on routine basis. There had been no improvement to the arrangements to manage the patients held in the corridor area. We found that very unwell patients were being held there with very little or no supervision this included patients with cardiac issues and sepsis.
- The performance in relation to the 15 minute face to face assessment, four hour standard and ambulance

Urgent and emergency services

handovers remained very poor and had deteriorated since the last inspection. Black breaches had increased fivefold from 199 in 12 months in the last inspection to 218 in one month during this inspection.
- Clinical guidelines were not always followed and we found occasions when this had negatively impacted on patient outcomes.
- The department had undertaken one national audit since the last inspection and this showed that they were not complaint with all four standards looked at.
- Audit findings were not always actioned and action plans were not always monitored.
- Patients were left in an undignified manner in the corridor areas including having physical examination in the corridor areas. Some patients told us that they were humiliated by their treatment.
- Medical staff did not always feel supported and felt that their education and development program was not sufficient.
- The viewing room for deceased patients had not improved since the last inspection and remained visibly soiled and clinical.
- We found that deceased patient's property was not treated in a sensitive manner and we found bags of unlabelled property stacked up on the floor in the viewing room.
- We observed very poor record keeping which we saw negatively impact on patient care and safety, including staff being unaware that a patient had left the department until three hours later when inspection team noted this.
- There was routine overcrowding and the department consistently failed to meet the department of health standard of seeing, treating and discharging or transferring patients within four hours.
- Some risks were not identified or mitigated appropriately.
- Medical staff told us that concerns they raised were not listened to or acted on.

However:

- Staff were knowledgeable about how to manage safeguarding issues and we observed them acting on safeguarding concerns appropriately.
- Equipment was checked regularly and appeared to be in good working order.
- The paediatric department had improved their safety since the last inspection.
- Staff told us that since the new matron and nurse consultant had been appointed, safety was more of a priority and focus.
- Staff spoke positively about the newly appointed matron and the changes she had implemented.
- Staff sought appropriate consent from patients before delivering treatment and care.
- The department had a team of highly skilled and competent nurse and medical staff.
- Appraisal rates were much improved from the last inspection.
- Staff were observed to be treating patients with compassion and dignity in their one to one interactions with patients.
- Some patients spoke positively about the way staff treated them.
- Staff were caring and compassionate in their approach to patient care.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

We rated the Emergency and urgent services at Stepping Hill as inadequate in relation to safe because:

- There had not been sufficient progress to address safety concerns from our last inspection. Safety was still not a sufficient priority
- Early warning scores (EWS) designed to identify patient who were deteriorating, were not completed in line with the trusts protocol in all cases we reviewed.
- The recognition and management of sepsis remained unsatisfactory for the service following the findings of the last inspection. We reviewed two patients with suspected sepsis and found that neither patient had received care in line the trusts own policy.
- The trust sepsis audit for the last twelve months showed that less than 60% of patients with a diagnosis of sepsis received antibiotics within one hour of presentation.
- We found that infection control and prevention remained an issue within the adult department. We observed that trolleys and cubicles were not always cleaned between patients use and the sluice room was found in visibly soiled state.
- Infection control audit results were below expected levels and significantly so in some areas including the management of intravenous cannulas which scored an average of 50% compliance against a target of 90%.
- We found that patients were not always isolated when they had a suspected communicable infection.
- We found that medications security still remained an issue although this had improved significantly since the last inspection. We found some tablets and fluids left out on side in resuscitation room and drawer system to secure medications was found to open and accessible on two occasions.
- Patients were not always seen quickly by a nurse or doctor when they initially presented to the department for triage. For the period January 2016 to March 2017, the department's median performance against this standard was longer than 15 minutes for all months in relation to both ambulance handovers and walk in patients.
- We observed patients were still being accommodated in the main corridor of the department on a regular basis. It remained that the corridor was not equipped with the same equipment you would find in a designated emergency department space including a lack of piped oxygen and suction and monitoring equipment, which may have been required in an emergency situation. We raised this during the last inspection in January 2016 and found that this had not been improved or progressed since the last inspection.
- We identified five patients who were acutely unwell and were accommodated in the corridor.
- Training levels provided by the trust showed that 20.5% of clinical staff working in the emergency department had undertaken level 3 safeguarding children training.
- We found that the documentation of nursing care remained an issue from the last inspection. We found that some patients did not have any nursing records completed apart from their triage section. One of these patients was being treated for a serious infection and was awaiting an inpatient bed. The patient approached us and asked what their plan of care was. When we approached staff and asked them; they were unaware of where the patient was located and could not tell us what the patient's plan of care or progress was.
- In another case we found an empty cubicle space with an intravenous line still on the trolley stand with a cannula attached. Staff were unable to locate the patient and there was confusion over where the patient had gone. We were informed the next day that the patient had in fact been discharged but this was not documented in their records.
- The department used an electronic board which was not always updated with the correct patient locations. We found three patients in the corridor areas of the department who had been moved location. The patient's location had not been changed on the board and therefore staff were unaware of where patients were located.
- Nurse staff remained an issue from the last inspection; shift fill rates for nursing staff were consistently below 80%.
- There was a reliance on agency and bank staff which was unsustainable in the longer term.

However:

- Staff were knowledgeable about how to manage safeguarding issues and we observed them acting on safeguarding concerns appropriately.

- Equipment was checked regularly and appeared to be in good working order.
- The paediatric department had improved their safety since the last inspection.
- There were appropriate major incident plans in place and staff were knowledgeable about these.
- Staff told us that since the new matron and nurse consultant had been appointed, safety was more of a focus. However they had been in post a short time and significant safety issues persisted.

Incidents

- All staff had access to the trust wide electronic incident reporting system. Staff were aware of what type of incidents they should report and were able to show us how they would report an incident. Staff told us that they did receive feedback from the Matron or nurse consultants on all incidents they raised. Staff told us that they felt more involved in incident investigations since this last inspection in January 2016.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). Seventeen serious incidents were reported to STEIS between February 2016 and February 2017. We reviewed three root cause analysis investigation reports pertaining to incidents during this period. We found that two of these were comprehensive and identified learning points where appropriate. In one case we found that the investigation was not comprehensive and did not identify learning points. In all three cases we found that some actions lacked due dates, were past their due date and had not been updated.
- Learning from incidents was shared with staff on a one to one basis by the medical and nursing management team. Key issues arising from incidents were also discussed within the monthly governance meeting.
- Strategic data from the service showed that staff reported 728 incidents for the service between February 2016 and February 2017. Of these 34 incidents were reported as occurring in the paediatric area and 18 incidents occurred in the clinical decision unit. The highest category of incidents was the identification of pressure ulcers which had been acquired prior to patient's attendances. The second highest reporting category was medication incidents, which accounted for 52 incident reports.
- Staff were aware of duty of candour which is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. We found that duty of candour was considered and exercised as part of incident investigations. However in one serious incident we found that duty of candour had not been exercised for over twelve months after the incident.

Safety thermometer – need more data around avoidable harm

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- The Emergency Department were not recording and monitoring data in line with this initiative.

Mandatory training

- Staff told us that they were encouraged to attend mandatory training and that the Matron prompted them when their training was due to expire.
- The uptake levels for mandatory training varied across levels with most subjects having a lower level of uptake than the trusts target.
- Only 81% if staff had undertaken the safe use of insulin mandatory training which was below the trusts target of 90%. As was medicines management training levels which were 84%.
- Staff were required to undertake basic life support once yearly which equipped them with the skills to undertake resuscitation procedures if required. The training level for basic life support was well below the 90% target at 74%. This meant that 26% of staff working in the emergency department did not have the up to date skills to undertake basic life support and resuscitation procedures. However this was an improvement on the compliance levels during the last inspection.
- The training rate for venous thromboembolism recognition and management was also below the target of 90% at 67%. However this was an improvement on the compliance levels during the last inspection.

- However training rates for fire safety, health and safety and manual handling were all above the trusts target of 90%.
- We requested information relating to how many staff had up to date advanced life support, advanced trauma life support and advanced paediatric life support. The trust did not provide this information.

Safeguarding

- The emergency department records contained a safeguarding trigger area to prompt staff to consider safeguarding issues. We reviewed eight children's records specifically in relation to the safeguarding trigger part of record and found that all eight records had the safeguarding trigger section correctly completed. In one of these cases a safeguarding issue was identified by staff and we observed that they acted on this appropriately and took all relevant steps to safeguard the young person in question. We reviewed 11 adults specifically in relation to the safeguarding trigger part of record and found that all 11 records did not have this section completed.
- Safeguarding training formed part of the trust's mandatory training programme. Data provided by the trust showed that there was compliance with safeguarding training for nursing staff in urgent and emergency care services. Compliance with training for safeguarding adult's level 1 was 91% which was higher than the trust's target of 90%. However safeguarding adult's level 2 training was lower than the trusts target at 83%. In addition, the compliance level for safeguarding children level 1 was 95% which was above the trusts target however the compliance level for level 2 safeguarding children was below the trusts target at 88%.
- Data provided by the trust showed that 20.5% of staff working in the emergency department had undertaken level 3 safeguarding children training. The percentage of paediatric nurses working in the department who had undertaken this training was higher at 86%. The intercollegiate document 'Safeguarding children and young people: roles and competencies' (2014) sets out the levels of competencies and training required for staff working with children and young people. This document states that all staff that assess, plan, intervene and evaluate care with children and their parents should undertake training at level 3. Therefore the service was not meeting this national guidance as they were providing care and treatment for children on a daily basis.
- Staff were able to explain the application of the law and their responsibilities in relation to female genital mutilation. There was also clear guidance available in the emergency department in relation to this subject. Staff gave us examples of when they had suspected female genital mutilation and told us how they had acted on this.
- Staff were knowledgeable about child exploitation and trafficking and considered this as part of their patient assessments.
- Staff considered domestic violence in their patient assessments and were aware of signs and indicators of domestic violence.
- Staff told us they received feedback from all safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff and their managers
- The trust had safeguarding policies and procedures in place. Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. Staff showed us how they would access the trust intranet page relating to safeguarding and the trust had an internal safeguarding lead and team who could provide guidance and support to staff in all areas. Staff were able to name this lead and told us that they were a visible presence and a good source of support.

Cleanliness, infection control and hygiene

- The training uptake levels for both levels of mandatory training in infection control and prevention for staff working in the department were above the trusts target of 90%.
- We observed that cubicles and trolley spaces were not always cleaned between uses during busy periods. However during less busy times we did observe staff cleaning trolleys and cubicle spaces.
- We found that the decontamination room which was also used a deceased viewing room was still visibly soiled. This was despite highlighting this to the trust during our last inspection in January 2016.
- Staff were observed using personal protective equipment, such as gloves and aprons and changing

this equipment between patient contacts and we saw staff washing their hands using the appropriate techniques. We saw that staff followed the 'bare below the elbow' guidance.
- There was adequate access to hand washing sinks and hand gels.
- We reviewed hand hygiene audit results for a six month period. These showed an average compliance over this period which was lower than expected by the trusts at 68.8% against a standard of 90%. We also reviewed the environmental and clinical practice infection control audits for the same period and these showed that the department performed well below the expected standard with an average score of 52% against the 90% standard.
- The service also undertook audits which looked at how well the infection control and prevention measures in relation to indwelling devices were managed. For both the urinary catheter and cannula care audits the service scored significantly below the expected standard for the same six month period with a compliance rate of 50% against the 90% standard.
- The department undertook early screening for infections including MRSA and CPE during patient admissions. This meant that staff could identify and isolate patients early to help prevent the spread of infections. We observed that this was routinely undertaken even during busy periods.
- There were appropriate facilities including three individual rooms to isolate patients with a suspected infection. However we found that one patient who had presented with vomiting and diarrhoea was not isolated appropriately. This patient had been in the department for over eight hours and staff had not noted that they required isolation. The patient was allocated a bed on an inpatient ward which was not isolated and the receiving ward had not been informed by the department that the patient had vomiting and diarrhoea.
- We observed on one day of the inspection during a very busy period that the sluice room did not have a lock on the door. When we entered we found a bottle of half full whiskey and numerous cleaning fluids in unlocked cupboards and on shelves in this room. Some of these fluids were toxic and could be very harmful if ingested. We highlighted this to the management team who acted immediately and ensured the room was fitted with a lock within two hours.
- We also noted during this inspection of the sluice room that commodes were visibly soiled with yellow and brown stains. They also did not have 'I am clean' stickers attached which the trust uses to ensure staff knew when an item is clean and ready for use. We also found a bed pan underneath a sink in the room with yellow fluid present. We highlighted this to the management team and when we returned the next day and on our unannounced visit we found that the commodes were visibly clean and labelled with 'I am clean' stickers.

Environment and equipment

- Equipment in all areas of the department appeared well maintained with up to date portable appliance testing stickers where appropriate.
- There was a maintenance schedule which was facilitated by the trust wide maintenance team.
- Staff told us they had easy access to the equipment they needed to care for patients. However when we reviewed incident report records we found that here were numerous occasions when patients encountered delays in receiving important medications due to lack of availability of infusion pumps.
- Records indicated that staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was in place and records indicated it had been checked daily, with a more detailed check carried out weekly as per the hospital policy.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. On two days of the inspection we observed that there were sharps disposed of in a bin which was not designed for their disposal and did not have a lid. This posed a risk of injury and communicable disease transmission to staff working in the department. We highlighted this to the management team immediately.
- There was an x-ray department situated next to the unit for easy access which also provided portable x-rays.
- Security staff were available on site 24 hours a day and were able to be contacted by telephone, if required. Staff also had an emergency alarm which they could activate in the event of an emergency which alerted security wherever they were in the hospital.
- In the paediatric area the facilities were very well maintained and segregated securely from the adult department.
- Appropriate equipment was available in all clinical areas in the paediatric area including all equipment which

could be required specifically for children. Equipment was checked regularly and we reviewed the records for these checklists for a four week period and all checks were fully completed for the period.

- The admission route for patients was set up so patients arriving by ambulance were seen and triaged in a designated cubicle area by a designated ambulance triage nurse. However this area was frequently full to capacity and patients were therefore triaged in the corridor area.

Medicines

- An electronic storage system was used to store and dispense medicines in the major's area of the department. Access to this system was secure and required fingerprint and swipe access. We observed two occasions when the drawer system was left slightly open and therefore left open access to medication stored in this system.
- There had been 52 incidents relating to the management of medicines reported for the department in the 12 months prior to the inspection. This was the second highest category of incidents within the service.
- Staff told us that the system for administering and prescribing medications for patients allocated inpatient beds was unsafe. The department operated an electronic system of prescribing which did not transfer to the main hospital electronic prescribing system. Therefore the inpatient teams reviewing patients in the department would complete a paper based prescription chart. This meant that there was the potential for errors and double dosing of medications. It also meant that staff working on inpatient wards could not access records to inform them as to what medications patients had received in the emergency department. We highlighted this as a risk to the trust during our last inspection and we were assured that this would be addressed. We found that there had been modest progress to improve this risk. A corporate risk assessment had been undertaken in relation to these issues which recognised the risks and put in place some actions to mitigate against those risks. There were also plans to introduce the electronic patient which will align the department with ward based prescribing.
- There were five fridges which were used to keep medications in the department. One was situated in the resuscitation area which was locked using a padlock in an openly accessible area, one was in the paediatric area in a locked room and three were situated in a locked medication preparation room. We found that the fridges in the paediatric area and the medication preparation area were locked securely when checked on all days of the inspection. We found the fridge in the resuscitation area unlocked on the first day of inspection. We highlighted this to senior staff in the department and found that on subsequent days this fridge was locked. All other fridges were found to be securely locked.
- We found that the daily checks required for the fridges in the emergency department were undertaken for all days in a one month period.
- Patient Group Directives (PGDs) were in use and there was a procedure in place to review them. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. PGDs were being used by the triage nurses and emergency nurse practitioners in the minor's area to support patient access to medicines in a timely way.
- Controlled drugs were stored appropriately in locked cupboards in line with legislation on the management of controlled drugs. Records showed that these medications were checked on a daily basis. Controlled drugs require additional checks and special storage arrangements because of their potential for abuse or addiction and also require clear and precise documentation of any wastage. We found that staff undertook appropriate checks when administering controlled drugs and documented the administration and checking appropriately.
- An audit undertaken in 2016 which looked at the management of controlled drugs found that in the resuscitation area of the department there were three areas for improvement in relation to the reconciliation of controlled drugs. These were relating to documentation which was required when stock was received and the area was found not to have a stock list of controlled drugs. We requested the action plan in response to this audit and it was not provided.
- We also found oral medication left out on the side in the resuscitation area on one occasion. The medications on the side included medication for cardiac problems and epilepsy which could; if taken inadvertently or by the wrong patient cause they harm. We highlighted this to staff who rectified the issue immediately.

- In the adult department we found that all oral liquid medications were correctly labelled with an opened date. In the paediatric department we found that four bottles of liquid medication did not have apart from one bottle of morphine sulphate which did not have an opened date documented.
- Medications brought into the hospital by patients and their relatives were stored securely. We had raised an issue relating to this with the trust during the last inspection in January 2016. We found that the department had improved in this area and we found that patient's medications were stored in the designated green bag system at all times.
- We found that medications which required a double check and signature by two nurses were not always completed correctly. We reviewed four records which showed that medications including controlled drugs and intravenous antibiotics had been signed to state that a staff member had administered them but the second check signature was completed sometime afterwards in some cases hours later.
- There were appropriate processes in place for ordering medications and stock reconciliation.
- Discharge medications and prescriptions were managed well. Prescriptions for these medications were completed legibly and records for take home medications were amended accordingly. Discharge notifications were provided to patients and to their GPs where appropriate.
- Guidelines on the use and preparation of medication were readily available including specific guidelines for children in the paediatric area of the department.

Records

- The department used electronic, computer based patient records and very few paper records. Electronic records were secure, restricted to authorised access and easily accessible to authorised staff via the ED computer system.
- The matron for the department undertook weekly and monthly record reviews in the form of nursing care indicators. These indicators showed a mixed rate of compliance across the six month period prior to our inspection. These indicators covered a range of documentation areas within the emergency care record, these included pain score documentation, nursing documentation, risk assessment completion and documented discharge plan. The service performed well for the documentation of a discharge plan with 100% of records reviewed meeting these criteria for the six month period. The documentation of pain scores was also above the expected target for 11 out of 12 months audited. However there were areas which scored lower than the expected range including the documentation of a nursing assessment which scored below the 90% standard on seven out of 12 months audited. For two of these months the score was below 50% and for the last five months prior to the inspection the service had scored 80% on each month consecutively.
- Some paper records were left unsecured in pigeon holes in front of the nursing station and were mixed together. These records were accessible to staff, patients and members of the public. We raised this with the department management team and they arranged for records to be separated in these pigeon holes but they were still left unsecured and accessible to members of the public attending the department.
- The nursing records section of the electronic notes system contained important prompts for staff to document that patients had been assessed and received care. We found that some patients did not have any nursing records completed apart from their triage section. One of these patients was being treated for a serious infection and was awaiting an inpatient bed. The patient approached us and asked what their plan of care was. When we approached staff and asked them; they were unaware of where the patient was located and could not tell us what the patient's plan of care or progress was.
- In another case we found an empty cubicle space with an intravenous line still on the trolley stand with a cannula attached. We asked staff where the patient was and they were initially unable to tell us as the records were not up to date. After 30 minutes of attempts by staff to locate the patient we were informed that they had been admitted to an admissions ward. Two hours later we found that the patient had not arrived at the admissions ward and was unable to be located. We raised this with the management team immediately who began investigations to locate the patient. We were informed the next day that the patient had in fact been discharged but this was not documented in their records.
- The department used an electronic board which was not always updated with the correct patient locations. We found three patients in the corridor areas of the

department who had been moved location. The patient's location had not been changed on the board and therefore staff were unaware of where patients were located.

Assessing and responding to patient risk

- Patients who self-presented to the department were seen by one of two receptionists and were booked in and directed to the waiting room where they were triaged by a nurse.
- Patients arriving by ambulance were alerted to the ambulance triage paramedics working for the trust and triaged in a designated ambulance triage cubicle.
- The trust used a recognised triage system for the initial assessment of all patients. Triage ensures that patients are directed to the appropriate part of the department and seen in a specified time frame decided by their clinical condition. Serious life-threatening conditions are also identified or ruled out so that the appropriate care pathway can be commenced without delay.
- The Royal College of Emergency Medicine (CEM) recommends that a face to face assessment of patients should be carried out by a clinician within 15 minutes of arrival or registration. This is to ensure that any potential life threatening conditions are identified and acted on as quickly as possible. For the period January 2016 to March 2017, the department's median performance against this standard was longer than 15 minutes for all months in relation to both ambulance handovers and walk in patients.
- The data relating to walk in patients showed that in this twelve months period the average time from arriving to initial assessment was over 35 minutes for all months. For seven out of 12 months the average time exceeded 45 minutes and for two months this time exceeded one hour.
- The data relating to ambulance arrivals showed that for 11 out of 12 months in this same period the time from arriving to initial assessment was over 20 minutes and in two of these months the time exceeded 30 minutes.
- During the last inspection we reported that there had been 199 black breaches between October 2014 and November 2015. We found that data showed that the number of black breaches had increased significantly. This data showed that for eight out of 12 months the number of black breaches exceeded 50 per month. For one of these months (January 2017) the number of black breaches was 218 which were higher than the previous year's total number. Black breaches occur when the time from an ambulance's arrival to the patient being handed over to the department staff is greater than 60 minutes.
- An early warning score (EWS) system was in use in the department. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly. Patient's observations and EWS were monitored using an electronic system which alerted staff when observations were outside of accepted parameters and were due to be repeated.
- In all cases we reviewed we found that observations were not completed in line with the trusts EWS guidance. In some of these cases there were significant delays of up to two hours in taking observations.
- In one case a patient had presented with sepsis. This patient had an early warning score of 7 which should have prompted continuous monitoring and observations repeated within 15 minutes. The observations were not repeated for one hour and 20 minutes. The trusts sepsis action tool stipulates that observations should be undertaken at one hour intervals at a minimum if sepsis is suspected. This was not met for the patient on three occasions and when the patients observations were repeated after one hour 30 minutes on one occasion the patients' blood pressure had significantly dropped and they required fluid resuscitation.
- During the last inspection in January 2016 we found that the department was not managing sepsis adequately. We instructed the trust to improve on this area.
- During this inspection we found that the department had a sepsis pathway in place and based on best practice and national guidelines. The electronic system prompted staff to consider sepsis and contained guidance on actions required in response to this condition. We reviewed two patients with signs of sepsis.
- One patient displayed signs of sepsis at triage and displayed two red flags. Despite this the sepsis

screening tool and pathway was not completed for the patient. They later received the diagnosis of sepsis. This patient did not receive care in line with the trusts sepsis action tool.

- The second patient had displayed two signs of sepsis and according to the trigger form used by the department should have met 'sepsis present' criteria. This meant that the patient should have received hourly observations, reassessment of sepsis and monitoring of urine output on an hourly basis. None of these interventions were undertaken for the patient and they were placed on a chair in the corridor without review for over three hours. A sepsis screen and pathway was not completed for this patient.
- The trust had undertaken a monthly audit of compliance with key aspects of the management of sepsis. This audit showed that between February 2016 and March 2017 less than 60% patients who required antibiotics for sepsis were administered these within one hour in line with the trusts requirements for treating sepsis. We also found examples of patient who had not been placed on the sepsis pathway in incident report records.
- We observed patients being accommodated in the main corridor of the department for two out of three days of the inspection. The time these patients were resident in the corridor ranged from a few minutes to just four hours. The corridor was not equipped with the same equipment you would find in a designated emergency department space including a lack of piped oxygen and suction and monitoring equipment, which may have been required in an emergency situation. We raised this during the last inspection in January 2016 and found that this had not been improved or progressed since the last inspection.
- There was no standard operating procedure in place which covered the use of the corridor. There was a risk assessment in place which did not stipulate or guide staff as to any criteria to follow to determine whether patients were clinically stable enough to be placed in the corridor. Staff told us that only stable patients, who were not at risk of deterioration, should be accommodated on the corridor area. The risk assessment also stated a control measure of 'intentional rounding'. We found that in five out five patient records we reviewed for patients being held in the corridor, there was no documented intentional rounding undertaken. One of these patients had been in the department for over two hours.
- We identified five patients who were acutely unwell and were accommodated in the corridor. Two of these patients had a suspected diagnosis of sepsis and another patient was suffering from acute new confusion. We also found a patient in the corridor who was accompanied by paramedics but had not been seen by department staff despite arriving 30 minutes earlier. The patient was not haemodynamically stable and had a suspected serious abdominal condition which had the potential to cause a life threatening haemorrhage. Another patient was suffering from chest pain and had a history of cardiac problems.
- Some patients were observed to be in pain and in a visibly distressed state in this corridor area. One patient was calling out for pain relief and staff could not tell us who had overall responsibility for this patient or others in the corridor.
- The corridor area was not equipped with call bells and the patients had no way to summon help apart from calling out. We observed that the majority of patients held in this corridor required a call bell to call for help due to the nature of their conditions.
- We found that patients were also being accommodated in the treatment room areas which lacked oxygen and suction equipment for use if patients became unwell. Staff could not tell us how they decided which patients were placed in these rooms and there was no document or guidance to assist them. We found two examples in incident reporting records which showed that patients placed in these areas had suffered collapses and required resuscitation.
- On admission staff were required to carry out risk assessments to identify patients at risk of specific harm such as pressure ulcers, self-harm and risk of falls. If staff identified patients susceptible to these risks, they would place patients on the relevant care pathway and treatment plans.
- We identified two patients who had presented with a history of self-harm and intentional overdose and staff had completed a self-harm risk assessment for both these patients.

- We saw evidence that comfort round took place to check if a patient needed water, access to the toilet, pain level or repositioning. However this was infrequent and in some cases completely absent.

Nursing staffing

- The staffing levels expected which were set by the trust on a day time shift for the department were 14 registered nurses and four health care assistants. These levels of staffing were frequently not met. In March 2017 prior to the inspection we found that on 28 out of 28 days reviewed the department was at least one qualified member of staff short. In some cases this figure rose to ten. In the same period we found that 15 of 28 days were short staffed by at least one health care assistant.
- The vacancy rates across the medical division were high at 17.3%. However the overall vacancy rate for the department was lower at 3.15%.
- Shift fill rates varied across the months but were consistently below 80%. In some cases the numbers of shifts unfilled by bank or agency staff exceeded 50%.
- Staff told us that they felt that staffing had improved since the last inspection and although they were still very busy they did feel more able to deliver the care they needed to.
- Only 20% of respondents to the 2016 staff survey agreed that there were enough staff in their area (emergency department) to do their job properly.
- We observed occasions where patient care was delayed during busy periods including moving patients to inpatient beds, providing food and drinks, undertaking clinical observations and medication administration.
- The department did not complete nurse staffing audits and did not use a workforce planning tool.
- The paediatric area was well staffed with competent staff. The department aimed to staff this area with registered paediatric nurses. If this was not possible then the area would be staffed by experienced nursing staff who had undertaken higher level safeguarding children training and more advanced paediatric life support.
- Staffing levels within the department were displayed on a board. The number of staff on duty was reflective of the duty rota.
- There was a reliance on agency and bank nursing staff. The number of agency and bank shifts frequently equated to half or more of the total number of staff working on a shift. The trust spent £8,700,829 on the employment of agency staff in the 2016/17 financial year. This was above their ceiling target of £6,998,844.

Medical staffing

- We requested the vacancy rate medical staff within the emergency department but this was not provided. We were provided with an overall rate for the medical division which showed that 17.3% of posts across the medical division were vacant.
- We requested the medical staffing skill mix for the emergency department however this was not provided.
- Consultants worked on a rota basis to provide cover on weekdays between 9am and 10pm. From 10pm until 9am the most senior doctor on duty would be a registrar grade doctor (very experienced senior doctor). Consultant cover after 10pm was available on an on call basis. During weekend periods consultant cover was provided in the department between 9am and 9pm. Outside these hours consultant cover was provided on an on call basis.
- There was a consultant with a responsibility and lead for paediatrics and they had additional qualifications to undertake this role.
- Some junior and registrar grade doctors told us that they were did not always feel supported by their seniors and they felt morale was low.
- Medical staff told us that the rotas for duty were frequently completed last minute and were only ever completed one month in advance which did not allow them to plan their lives around work.
- The general medical council had implemented enhanced monitoring of the trust medical staffing due to safety concerns raised by junior doctors in the emergency department.
- Nursing staff told us that they were able to access medical assistance and advice easily.
- We saw evidence that patients were seen promptly by medical staff if flagged up by the nurse following triage.

Major incident awareness and training

- The trust had a major incident policy in place which was available on the trust intranet site. Staff were able to tell us how they would access this policy and showed a good understanding of the policy.
- There were designated store rooms for major incident equipment.

Urgent and emergency services

- Staff received major incident training including participation in simulated training exercises.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- Action cards to guide staff on what to do during a major incident were easy to follow and fit for purpose detailing roles and responsibilities.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated urgent care services as requires improvement because:

- The department's pathways and treatment plans followed national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) but staff did not always follow these.
- The service participated in local and national clinical audits, however the results of these audits were below the expected standards and action plans had not fostered meaningful improvements.
- Pain relief was managed effectively and audited on a monthly and weekly basis. However we did observe that it was delayed during busy periods and we observed one patient in distress.
- Data from national surveys showed that patients treated within the hospital had outcomes which were worse than expected in some cases.
- Medical staff told us that they felt they didn't have sufficient opportunity for development and that they felt that the medical education program was poor.
- Staff did not have a good understanding of the Mental Capacity Act (2005) and did not undertake assessments in line with this.

However:

- There was access to food and drink but the provision of this to patients was variable.
- Staff sought appropriate consent from patients before delivering treatment and care.
- The department had a team of highly skilled and competent nurse and medical staff and appraisal rates were much improved from the last inspection.

Evidence based care and treatment

- The emergency department used both National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to guide the care and treatment they provided to patients. However these guidelines were not always followed. An example of this was the management of sepsis. We found that the trusts guidelines which were based on national guidelines and papers were not followed in two cases we reviewed.
- A range of evidence based clinical care pathways were available electronically and put in place for patients with relevant conditions. These included sepsis, stroke and certain fractures. These pathways included prompts and treatment steps for staff to follow. Patients were required to be placed on appropriate pathways as soon as their condition was diagnosed which ensured that they received timely and appropriate interventions. The pathways were regularly reviewed on a trust wide basis and reflected current guidance from NICE and RCEM.
- We found that these pathways were not always put in place or followed. An example of this was a patient who presented with chest pain and was later diagnosed with a myocardial infarction. The chest pain guidelines and pathway recommended an immediate electrocardiogram (ECG) and administration of aspirin if not contraindicated. This patient did not undergo an ECG until two and half hours after their presentation. They did not receive aspirin until eight hours after their presentation.
- Another example was a patient who was receiving chemotherapy and presented with a low temperature. The trusts pathway for this presentation stipulated that if a patient was receiving chemotherapy and presented with a low temperature they should receive antibiotics within one hour of presentation. This pathway was in place as patients receiving chemotherapy are at a higher risk of developing life threatening sepsis. This did not occur in this patient's case and the patient was not seen within one hour. They subsequently left the department to seek treatment elsewhere as they were concerned about the delays.

- We also found that in the case of two serious incidents clinical guidelines in place were not followed and this was listed as a main contributory factor of the incidents. In one case the patient involved unfortunately died as a result of the incident.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.

Nutrition and hydration

- Staff had access to facilities for making drinks and food such as sandwiches was available if needed.
- We observed that some patients were offered food and drinks by staff members. However three patients told us that they had not been offered any food or drink despite being in the department for a number of hours. One patient told us that they had asked for a drink and a staff member told them that they could not have one as they would have to make everyone a drink if they gave this patient a drink.
- Staff identified patients who were not able to eat and drink and their records reflected their needs clearly. Staff provided assistance to patients who required it.
- We identified three patients who required their fluid balance recording and in all cases the fluid balance was either absent or incomplete. Two of these patients had a suspected sepsis diagnosis and one required monitoring for their renal function. The trusts sepsis action tool states that close fluid balance monitoring including hourly urine monitoring should take place in any diagnosis of suspected sepsis.
- The trust scored about the same as other trusts of a similar size in England for the one question related to nutrition and hydration in the A&E survey 2014.

Pain relief

- In the A&E survey 2014 the department scored about the same as other trusts in England for all indicators relating to timely access to pain relief.
- We observed that pain relief was routinely offered on triage to walk in patients experiencing pain. This pain relief was commensurate with the patient's level of pain.
- Audits of pain relief provision were undertaken locally on a monthly and weekly basis. These showed that the service performed above the expected 90% standard for most months over a twelve month period. The areas covered in these audits were relating to pain score documentation and provision of pain relief in a timely manner.
- The department undertook monthly care indicators which looked at how pain relief was managed for adults and children. These indicators showed that for ten months out of 12 (February 2016 to March 2017) the department had scored above 90% in relation to the management of pain relief.
- We reviewed one patient record relating to a patient suffering from dementia who had suffered a displaced fracture. The patient pain score was documented as zero, however the patient was in clear distress and was crying out in pain.
- The trust scored about the same as other trusts of a similar size in England for both questions related to pain relief in the A&E survey 2014.

Patient outcomes

- The department participated in the national Royal College of Emergency Medicine (RCEM) audits. RCEM audits allow trusts to bench mark their practice against national best practice and encourage improvements. The department had participated in one such audit since the last inspection. This audit was the recording and management of vital signs in children. The results of this audit showed that the department was not compliant with four out of four standards looked at. The associated action plan had a target due date of March 2017. We found that this had not been updated to reflect any changes to practice or improvements.
- The department participated in the national Royal College of Emergency Medicine (RCEM) initial management of the fitting child audit 2014/15 audit. They scored 100% compliance with three of the standards in this audit. In one the standards which related to documenting an eye witness history the department scored 94% which was lower than the 100% target. They also scored lower than the 100% standard in the measure relating to provision of discharge information to parents with 24% compliance against the 100% standard. An action plan in response to the areas which did not meet the standards was in place. These actions were all due to be completed by December 2015, but had not been completed by the time of our visit in January 2016 and there was no update recorded against these actions during this inspection either.

Urgent and emergency services

- The unplanned re-attendance rate for urgent care service within seven days was between 6% and 7% between January 2016 and January 2017. This meant that less patients re attended A&E in this trust than others in England.

Competent staff

- We found that 91.5% of nursing staff within the department had received their annual appraisal. This was slightly below the trusts target of 95% but had improved significantly since the last inspection. An appraisal gives staff an opportunity to discuss their progress and any concerns or issues with their manager. The rates of appraisal for medical staff was significantly lower at 50%.
- The nursing and medical staff were positive about learning relevant to their role and development opportunities. Staff told us that they felt able to seek further development opportunities and that this was actively encouraged by the new matron and nurse consultant.
- The newly appointed matron and nurse consultant had plans in place to improve development for staff working in the department and had discussed these in staff meetings.
- The nurse consultant would work alongside staff and provide real time supervision and training as needed.
- A number of newly appointed advanced nurse practitioners had taken up post and this provided development opportunities and pathways for staff working in the department while also improving the provision of services to patients.
- Medical staff told us clinical supervision was available and they felt adequately supported.
- New nursing staff received emergency department specific competency based training. They were supported by a mentor and were supernumerary for a period of time which varied depending on their previous experience and learning needs.
- Medical staff told us that they did not feel they had sufficient developmental pathways and support. They also told us that they felt the education program for doctors was very poor and did not make them want to stay employed in the trust.

Multidisciplinary working

- There was effective communication and collaboration between multidisciplinary team members within the emergency department and other specialities. Staff told us that medical and surgical doctors routinely attended the department to review patients and provide support.
- Multidisciplinary staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.
- Nursing staff told us they had good relationships with consultants and doctors of different disciplines. We observed the senior consultants leading the department working closely with the shift coordinator to facilitate patient care and flow.
- Medical staff told us they were not always informed of developments in the department. An example of this was that they were unaware that paramedics had been employed to triage patients arriving by ambulance.
- Staff told us they received support from pharmacists, physiotherapists, occupational therapists, social workers and diagnostic support.
- The RAID team who were employed by a neighbouring trust; provided mental health services and worked closely with staff to ensure patients were supported on discharge.
- Staff working for two ambulance services told us that they felt the staff in the department communicated effectively and they told us that they felt the communication had significantly improved since the appointment of the new matron.

Seven day services

- Access to radiology services was available 24 hours a day, seven days a week.
- Consultants provided on call cover for 24 hours, seven days a week. A middle grade or registrar doctor was also present in the department 24 hours each day, seven days per week.

Access to information

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- Staff in the department used electronic, computer based system for recording all care. All staff could access these records from tablet and computer devices.

Urgent and emergency services

- The records we looked at were easy to locate on the system and easy to follow. This meant staff could access all the information needed about the patient at any time.
- Medical staff produced discharge summaries and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might
- We saw patients being transferred from the department to medical and surgical wards. The information provided in these handovers was accurate and detailed, which ensured that the receiving staff had all the relevant information they needed.

Consent, Mental Capacity Act and DOL's

- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records where appropriate.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.
- 84% of staff had undertaken he mandatory training provided by the trust on the mental capacity act (2005).
- Staff did not have a good understanding of the legal requirements of the Mental Capacity Act 2005 and assessments of mental capacity were not undertaken when indicated. An example of this was a patient who had confusion and a history of dementia. The decision was made to administer treatment to this patient and they were resisting this treatment. There was no assessment of the patients mental capacity or evidence of discussion of a best interests decision
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards during working hours. During out of hours period's staff were able to seek advice and support from the senior nurse on site.

Are urgent and emergency services caring?

Requires improvement

We rated caring as requires improvement because:

- Although staff tried their best to ensure that patients received compassionate and dignified care, due to pressures within the department, patient's privacy and dignity was not always maintained.
- We observed occasions where patients were treated in the corridor in a state of undress.
- Some patients told us that they felt their care was undignified and one patient told us they felt humiliated.
- Staff did not always have time to support patients and ensure that they knew what was happening to them.
- We also observed that patient's personal property was piled up in the deceased viewing room with no identifying tags on it. We asked staff if they knew who it belonged to and they told us that they did not know but believed it belonged to deceased patients.
- Audit results from the department showed that they scored below the 90% standard for six out of twelve months the privacy and dignity indicator audit undertaken on a monthly basis.
- Patient's confidentiality was not always maintained as there was a visible screen in the department with patient's details visible and conversations held in the triage area could be overheard in the waiting area.

However:

- Staff were observed to be treating patients with compassion and dignity in their one to one interactions with patients.
- Some patients spoke positively about the way staff treated them.
- Staff were caring and compassionate in their approach to patient care.

Compassionate care

- Data provided by the NHS friends and family test (FFT) showed an average of 20% of patients responded to this test which was a higher percentage of respondents when compared to the England average of 13%. This showed that for five out of 12 months at least 90% of patients, who completed the survey between March 20015 and March 2016 would recommend the emergency department at Stepping Hill hospital to their

friends and family. However the department narrowly missed the 90% benchmark for seven out of 12 months with between 80% and 90% of patients saying that they would recommend the emergency department at Stepping Hill hospital.

- The emergency department scored the about the same as other trusts for 23 out of 24 standards related to compassionate care in the 2014 A&E survey and better than other trusts in one out of the 24 standards.
- The department undertook weekly and monthly audits for a nursing care indicators program. The results of this audit showed that for six out of 12 months the service performed worse that the 90% expected standard for privacy and dignity. For four of these months the service performed significantly worse than expected with rates below 80%.
- Some patients and their relatives told us that they did not feel supported and that they did not receive compassionate care. On patients relative told us they felt that staff had ignored them since they had arrived.
- Following the last inspection we told the trust that they must improve the service to ensure patients received care which maintained their dignity and privacy. During this inspection observed occasions where patients dignity and privacy was not maintained.
- During busy periods the holding areas which were present during the last inspection were still in use and were situated on the main through corridor of the department and paper curtains had been installed around them. Patients were also held in areas where there were no curtains.
- The curtains in these holding areas did not fully enclose the patient's trolley and when closed the curtains were approximately 10cm from the patient's trolley.
- We observed five patients receiving clinical care in this corridor area with either the curtains open or on the corridor. This included patients and the procedure fully visible to members of the public and staff passing by. The patients were receiving various interventions including blood tests, intravenous cannula siting and physical examinations. In one of these case the patients was undressed in the corridor and was left with a bare chest.
- Two patients told us they felt undignified being examined in the corridor. One patient told us they felt humiliated as they were in the corridor in thin night clothes with staff and members of the public passing by.
- The main electronic tracking screen for the department which displayed patient's full names and clinical status was still situated in the middle of the department and was visible to members of the public attending the department.
- The triage area situated in the main reception area was still separated by a curtain. We observed that patients triage could still be heard clearly from the waiting room including sensitive clinical details.
- Six patients told us they felt that they had received compassionate care from staff in the department. We also observed staff treating patients in a compassionate manner when the department was not overcrowded.
- Staff told us that they sometimes felt unable to provide care and undertake tasks to improve patient experience when the department was very busy. They also told us that they felt that this had improved with additional staff and the new matron who was in post at the time of the inspection.
- There were private rooms available where staff could speak to patients privately if required, in order to maintain confidentiality.
- In the deceased viewing room which was also used as a decontamination room, we found bags of patient's property stacked up and when we asked staff what these items were they told us that they belonged to patients who had died in the department. These belongings had no identifying features such as address labels and they contained personal belongings and items which may have been of sentimental value to patients relatives. We raised this with staff and they assured us that they would try and identify whose belongings they were and return them to their rightful owners. We found further corroborating evidence in incident reports which outlined incidents where deceased patient's property could not be located for family members.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a way they could understand.
- Most patients told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in

the form of written materials, such as discharge information leaflets specific to their condition. Two patients told us that they had not received any information about their care and treatment plan.
- The department scored about the same as other trusts in England in relation to questions about the amount of information patients received and how involved they were with their care in the 2014 A&E survey
- Staff were able to tell us how they would identify when patients required additional support such as advocacy and told us that they knew how to access these services if they identified this need.

Emotional support

- Patients and relatives told us that staff supported them with their emotional needs.
- There was a viewing room available for deceased patients so that their relatives could be with them and grieve privately. This room was also used as a decontamination room during major incidents.
- We observed the room and it was very cold and visibly soiled. The room was clinical without any comforting features that may help relatives when experiencing such a difficult time. There was also patient property piled up in this room with no identifying information. Staff told us that this was likely to belong to deceased patients but they could not identify who these patients were.
- Chaplaincy services were available on site and staff were able to tell us how they would access these for patients.
- There were private rooms available for patient's relatives to wait when patients were very unwell or deceased. These rooms were equipped with comfortable seating and drink making facilities.
- Staff confirmed they could access management support or counselling services after they had been involved with a distressing event.

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

Requires improvement

We rated responsive as inadequate because:

- Patients frequently and consistently experienced unacceptable waits and were not able to access emergency care in a timely way. There was routine overcrowding in the adult department and this impacted negatively on patients care and treatment. However the trust had taken actions to try and improve these waits for patients.
- Ambulances crews were sometimes queued in the department corridors and handovers were often delayed, in some cases for over, on occasions these handovers were delayed over 60 minutes.
- Patients in the adult department often experienced excessive and unacceptable waits to see a clinician and be allocated an inpatient bed.
- The Department of Health standard for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust consistently failed to meet this standard and was one of the worst performing in relation to this standard in the greater Manchester area. This was despite extensive support from external agencies including NHS improvement.
- Patients were frequently accommodated in the main through corridor of the department. This corridor was not equipped to accommodate patients for any length of time. It lacked adequate privacy measures and there were limited means for patients to call for help and assistance. The service had undertaken some actions to address this issue but this remained a concern at the time of the inspection.
- The deceased viewing room was not fit for purpose and did not meet the needs of deceased patients and their families.

However:

- The department did have a dementia Trolley which consisted of a variety of items to reduce distress behaviours and anxiety. The items consisted of music, activity mitts, and doll therapy. There was also a dementia champion who led on dementia training for all staff in the department.
- There was a separate paediatric department which was well equipped to deal with paediatric patients and patients in this area experienced minimal waits to be seen and referred to appropriate specialities.

- The trust had an escalation plan in place for the trust as a whole and also an internal escalation process. We found that staff did follow this most of the time and there was an improvement in staff compliance with this policy.
- The trust was trying to improve access and flow and had trialled a number of initiatives.

Service planning and delivery to meet the needs of local people

- The department was overcrowded and there were insufficient cubicle spaces. The trust had opened an area with six extra cubicle spaces however this had not provided the expected improvement in capacity.
- At times of peak demand patients conveyed by ambulances queued in the department's corridors and outside. The waiting room was also frequently crowded and on one day of the inspection there were large numbers of patients sitting on the floor.
- The trust had a designated paediatric area which was separated from the main department. This area contained all relevant equipment required for treating children and was securely segregated from the main department.
- There was a large local population of elderly patients in the Stockport area. In response to this the trust were working with a national charity to and avoid admissions from patients in this group. The department had also implemented a dementia screening prompt on all records and frailty screening on all records. We found these were not always completed and were not completed for two out of two patients we reviewed with a diagnosis of dementia.

Meeting people's individual needs

- The waiting area in the paediatric area was well equipped with toys and children's height furniture.
- There were adequate facilities to allow access and use by disabled patients. Including wide corridors and rails in disabled bathrooms. A patient who used a wheelchair for mobilising told us that they felt the department was very accessible and that their needs had been met.
- Information leaflets about services available and discharge advice were readily available in the department. Leaflets could also be provided in different languages or other formats, such as braille, if requested.
- Staff told us that they could access a language interpreter if needed and were able to show us how they would do this.
- Access to psychiatric support was readily available from the RAID team which was provided by a neighbouring trust.
- The department did not use a pathway when caring for patients living with dementia. However the department did have a dementia Trolley which consisted of a variety of items to reduce distress behaviours and anxiety. The items consisted of music, activity mitts, and doll therapy.
- The department also had a dementia champion who led on dementia training for all staff in the department.
- Families were also given This is me booklets to complete whilst in the department as this provided information on how to support the patient whilst they were in the department and also gave staff an awareness of likely triggers for anxiety and distress behaviours such as noise.
- Staff could also contact the Matron for Dementia Care within working hours if required to offer support to families, patients, and staff.
- We saw staff making adjustments to best care for a patient with dementia. Staff obtained a radio and placed this by the patient as her admission details stated music helped calm her in new environments.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).
- There was a viewing room available for deceased patients so that their relatives could be with them and grieve privately. This room was also used as a decontamination room during major incidents and had no comforting features which may have helped relatives experiencing such a difficult time. We highlighted this to the trust on our last inspection and found that it had not improved on this inspection.
- We found that the room remained cold and visibly soiled with brown stains to the floor and walls. The room was clinical without any comforting features that may help relatives when experiencing such a difficult time.

Access and flow

Urgent and emergency services

- There is a Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival. From January 2016 to January 2017, the hospital did not meet this standard for the twelve months. Their performance was consistently below 85% with an overall annual performance of 77.4%. The trust was the second worst performing trust in the Greater Manchester area in relation to this standard. We observed the department lacked capacity to accommodate patients. Nursing and medical staff told us that they felt unable to care for patients safely and effectively because of the lack of capacity in the department.
- On this last inspection senior staff told us that the main corridor of the department had been made into makeshift waiting areas. We were advised that these areas were only used as a last resort and it was not routine to accommodate patients in these areas for lengthy periods of time. However we found that this area was still being used to routinely hold patients and staff told us this was a daily occurrence and had become 'the norm'.
- We observed patients being accommodated in the main corridor of the department on two out of three days of our visit. The time these patients were resident in the corridor ranged from 20 minutes to just five hours.
- The trust had two escalation processes in place for periods when excessive demand was placed on the urgent care services. One of these processes was a hospital wide policy and process and one was specifically for the emergency department. The purpose of these policies and processes was to ensure the effective management of the trusts bed capacity and to give staff clear processes and triggers to follow in times of increased demand.
- The emergency department internal escalation policy gave four levels of escalation green, amber, red and black. Green meaning that the department was not over capacity and was able to cope with the demands placed on it through to black when the department was unable to cope with demand and the flow of patients was severely impeded. We found that the staff in the department were knowledgeable about these processes and followed them most of the time.
- During the last inspection we found that patients were not always moved to inpatient beds as they became available. We found that this was still the case although the number had reduced. At a time of peak demand when no cubicle spaces were available we saw that four patients had been allocated beds and had not been moved. We found no clinical reason to stop the moves and the time elapsed from the bed being available ranged from 30 minutes to an hour.
- We found that the emergency department live tracking screen was still not always updated with current patient locations. We observed delays of up to in entering patient's correct location of up to four hours. This meant staff were unaware of which patients were in their area and lent to an environment which was sometimes noted by staff and patients to be chaotic. We identified two patients who department staff were completely unaware of and were not on the electronic board. We identified a further four patient in incorrect locations and one patient who had left the department and this had not been noticed by staff.
- All staff we spoke with told us that they remained concerned about the capacity of the department and patient flow.
- The department had a clinical decision unit (CDU) which was used to accommodate emergency department patients who were awaiting clinical decisions and required an additional period of observation. We found that although some medical patients were accommodated on his unit the number had significantly reduced since the last inspection. Staff told us that this had improved their ability to stream patient through the department.
- Emergency nurse practitioners worked within the department and facilitated a minor injuries streaming system to treat patients with minor injuries. This helped improve the flow of patients through the department and reduced waiting times for patients with minor injuries.
- The department provided an Emergency Nurse Practitioner Service (ENP) which provided nurse-led care for all the adults and children who presented to the department and were streamed into the "minors' stream". The ENPs worked independently which helped free up medical staff to see patients with more complex problems and therefore contributed to improving overall performance in the ED.
- The department also had a team of Advanced Nurse Practitioners (ANPs) who assessed, examined, diagnosed and treated the whole range of patient presentations in department. This service was

developed as part of the workforce plan in light of local and national recruitment challenges. The ANPs are involved in departmental teaching, clinical audit and lead various clinical projects within ED.

Learning from complaints and concerns

- Information on how to raise a complaint was prominently displayed around the department.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient effectively.
- The service had received 110 complaints between January 2016 and January 2017, 69 of these complaints were upheld. Throughout these 13 months there were 103409 attendances therefore this equates to 0.07% of patients' complaints being upheld."
- The trust recorded complaints on the trust-wide system.

Are urgent and emergency services well-led?

Inadequate

We rated well led as inadequate because:

- Risks were not always appropriately identified, monitored and there was not always evidence of action taken where appropriate. One example of this was the poor performance in a number of care indicators.
- Significant areas of concern persisted across all domains from the last inspection. These had not been actioned at the pace expected.
- Audits and their results were not always acted on and identified as areas of concern by the senior leadership team.
- The senior management team working outside the service did not have a full understanding of the significant challenges that remained across the service.
- Areas for improvement were not always identified and appropriate actions plans were in some cases not in place and not updated.
- Medical staff did not always feel supported by managers and felt their concerns were not listened to.
- The new local matron level leadership had started to make some changes to improve safety however this was not moving at a sufficient pace to ensure safe care and treatment for patients.
- Staff were frustrated by the executive and divisional leadership and told us that they had continually raised concerns and felt they were not listened to. We saw evidence of this in incident reports where repeated issues around staff capacity to deliver care was impeded due to pressures in the department.
- In particular medical staff felt they were not listened to and their concerns were not actioned.

However:

- Nursing staff spoke positively about the matron and nurse consultant.
- Staff told us that the culture in the department had improved since the last inspection.
- Managers made efforts to engage the public and staff when planning services.
- The department had a business plan in place and there were areas of innovation.

Leadership of the service

- The local leadership in the department reflected the vision and values set out by the trust. Staff spoke positively about their local managers and leaders. Leaders were visible, respected and competent in their roles.
- Some staff told us that that they did not feel that their concerns were listened to by managers above matron level and that they were frustrated by this. An example a staff member gave to us was that they had repeatedly completed incident forms stating that they were unable to deliver aspects of care due to the business and pressures in the department. They advised that the matron had fed back to them about his and had offered support and had escalated their concerns but no meaningful change had taken place.
- There were clearly defined and visible local leadership roles in the department.
- Both the matron and nurse consultant were visible during our visit. Staff spoke positively about the changes implemented since the matron and nurse consultant had been appointed.
- Medical staff told us their senior clinicians in the department supported them well and they had access to senior clinicians when they required.

- However some medical staff told us that they felt unsupported by the executive level management team and told us that they felt the executives did not listen to their concerns about safety or take them seriously.

Vision and strategy for this service

- The trusts vision was to be nationally recognised for our specialism in the care of older people and as an organisation that provides excellent cancer care. The trust had a five year strategy which ran from 2015 to 2020 which set out key priorities for the five year period. Progress against this plan was measured at board level on a monthly basis.
- The trust said that they had a set of values which were based on three key themes Quality & Safety, Communication and Service. Underneath these themes were sets of expected behaviours set out.
- Staff we spoke with were aware of the trust vision and values and told us that they could locate these on the trust website.

Governance, risk management and quality measurement

- The department was part of the medicine business group. This business group is led by a triumvirate – the director, the head of nursing and the associate medical director. A governance lead was also identified in the business group. Locally the responsibility for governance was with the matron, nurse consultant, clinical director and clinical governance lead.
- The governance framework within the emergency department had improved since the last inspection. The matron and nurse consultant were aware of some of the issues identified and were reviewing incidents to identify themes. However there were still issues relating to the governance arrangements.
- A monthly nursing care indicators dashboard was completed by the department and fed into monthly governance meetings and up to board level. We found that there were a number of areas within this dashboard which had scored poorly consistently over a twelve month period. The matron was trying to address the issues identified but due to the breadth of the issues performance improvements in these indicators were not sustained and inconsistent. An example of this was the indicator for infection control and prevention. This indicator did not score above 90% for any of the 12 months for this indicator and compliance figures varied between 30% and 90%. Another example was the indicator for privacy and dignity where the data provided showed that for six out of twelve months this indicator scored below 90%. Neither of these issues were entered on the emergency department risk register. The trust provided an action plan during the factual accuracy process; which showed that the matron for the department had taken some actions to address these areas for improvement.
- The emergency department had a risk register which fed into the divisional risk register. The register identified risks and contained associated risk assessments with clear actions set out and timeframes.
- The register reflected some of the current risks the department had identified, for example registered nurse staffing. However some risks identified within the department were not present on this register. One example of this was the poor performance in a number of care indicators.
- The matron and nurse consultant were clear on their roles in relation to governance but acknowledged that there were areas which still needed addressing.
- There were regular monthly clinical governance meetings and we saw minutes from this meeting. The subjects discussed included current risks, themes and trends of incidents and recent incidents.

Culture within the service

- There was an open culture within the department where nursing staff told us that they were encouraged to raise any concerns about safety. Nursing staff told us that they had confidence that local leaders would act on any concerns they raised.
- However some medical staff told us that they would raise concerns but had little confidence that they would be listened to or actioned.
- Staff told us that they felt that the culture had improved since the appointment of the new matron and nurse consultant and that they had an open door policy. However staff told us that they had not seen any improvement in the pressures they faced from a lack of capacity in the department and long waits for inpatient beds.

- Medical staff told us that their morale was low and they felt unable to undertake their roles to their full capabilities due to the ongoing pressures in the department including lack of capacity and reduced staffing.
- Staff described the pressure in the department as relentless and some staff told us that they felt 'burnt out'.
- Three areas of the department had a sickness level of over 3.5% in January 2017 this had improved from 6.5% in January 2016. The top three reasons for sickness within the Medicine Business Group (including ED) were cold or flu, gastrointestinal illness and anxiety, stress and depression.
- The trusts had undertaken a staff survey in 2016. This survey showed that 80% of staff who responded felt enthusiastic about their job and going to work. In addition 66% of staff responded by saying they would recommend the department to their friends and family.
- All nursing staff we spoke with told us they felt respected and valued.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on number of incidents, complaints and the results of the NHS Friends and Family test was available in the department.
- The trust website provided information on how patients and their relatives could provide feedback to the trust and offered a number of ways to do so. The department also had an active service user group who were able to feed back any changes or improvements and were also consulted on any changes planned to the department.
- The department participated in the NHS Friends and Family test, which gives people the opportunity to provide feedback about the care and treatment they received.

Staff engagement

- Staff participated in regular team meetings led by the department's managers. Staff told us that they felt these meetings were informative and helpful.
- Staff told us they received support and regular communication from their managers in the form of emails, newsletters and individual interactions.
- All staff we spoke with told us they felt they had opportunity to discuss any developments or changes within the hospital.
- The trust also engaged with staff via newsletters and through correspondence displayed on notice boards in staff areas.

Innovation, improvement and sustainability

- We saw evidence in business plans and strategic objectives that leaders had assessed the sustainability of these plans and improvements. There was evidence that these were monitored and actioned where appropriate.
- The department had implemented innovative initiatives in their efforts to improve access and flow through the department. An example of this was the introduction of primary care streaming. This initiative meant that a practitioner would 'pull' patients from the triage stream if their presenting condition could be best seen by a primary care practitioner.
- The department had a full team of advanced and emergency nurse practitioners led by a nurse consultant. This highly skilled team of practitioners supported the medical staffing establishment to ensure patients were seen in timely way.

Medical care (including older people's care)

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

Information about the service

Stockport NHS Foundation Trust became one of the first Foundation Trusts in the country in 2004. They provide hospital services for children and adults across Stockport and the High Peak area, as well as community health services for Stockport, Tameside and Glossop. The trust work as part of the 'Stockport Together' partnership to integrate local health and social care more closely to people's homes.

Stepping Hill Hospital is the Trust's main acute site, which provides emergency, surgical and medical services. The trust serves a population of approximately 350,000 people. The medical services provided at the hospital included general medicine, endoscopy, cardiology, geriatric medicine, endocrinology, gastroenterology, rehabilitation, respiratory and stroke medicine. We inspected Stepping Hill hospital between 21 March 2017 and 22 March 2017.

From March 2016 – February 2017 the trust had 89,659 medical admissions including day case admissions. 28,390 of these admissions were from the emergency department. This averaged 7,472 admissions per month and with the exception on November 2016, remained around that average figure month on month.

During our inspection we visited the Acute Medical Unit (AMU), A1, A3, A11, A12, E1, E2, C2, C3, B2, B3 and the coronary care unit. We reviewed 24 complete (paper and electronic) patient records, 12 paper based patient records and a further 32 sets of electronic records, talked to 18 patients and 39 members of staff.

Summary of findings

We rated this service as requires improvement because:

- The trust had not responded appropriately to the risk expressed to them at our last inspection regarding the security of patients' records. Across the medical division in all areas we visited, except A11, records trolleys were unlocked. We were advised by the Trust that a decision had been made to keep records unlocked to ensure easy access to the records. Whilst the records trolleys were located at the front of nursing stations, we observed that these areas were not always manned therefore representing the same risk.
- The trust regularly moved their own staff and had a heavy reliance on agency and bank staff, resulting in inappropriate skills mix and staff feeling they were nursing in wards where they did not have the required competence to care for patients.
- Decisions to move nursing staff were made on clinical judgment without a clear guidance document or minimum set standards.
- Records completion was not in accordance with best practice guidance.
- Incident reports did not have consistent categorisation for the same type of incident.
- Infection protection audits showed low levels of compliance with the trust's policy. At the time of reporting action plans to address this were not provided.

Medical care (including older people's care)

- Safeguarding training levels for staff were not in accordance with the trust's own policy or best practice guidance.
- There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation. Decision-makers did not always make decisions in the best interests of people who lack the mental capacity to make decisions for themselves, in accordance with legislation. Restraint and deprivation of liberty were not always recognised, or less restrictive options used where possible. Applications to authorise a deprivation of liberty were not always made appropriately or in a timely manner to the Court of Protection or by using the Deprivation of Liberty Safeguards.
- The appraisal rate for the medicine division was 91.3% (88.1% in nursing care indicators), which was below the trust's target of 95%.
- The trust participated in the 2015 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 78.9%, which was worse than the audit minimum standard of 80%. The 2014 figure was 86.4%.
- Due to staffing pressures, patients' dignity was not consistently maintained.
- The arrangements for governance and performance management did not always operate effectively.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way. The risks and issues described by staff do not consistently correspond to those reported to and understood by leaders.
- The approach to service delivery and improvement was reactive and focused on short-term issues, for example nurse staffing.
- In view of the expenditure for agency staffing (£1, 138,444 for February 2017), the sustainable delivery of quality care was put at risk by the financial challenge.
- Some of the information that was used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant.

However:

- Staff understood their responsibility to report incidents.
- Staff were aware of the duty of candour and their obligations regarding this.
- All areas we inspected were visibly clean and tidy.
- Throughout our inspection, in most wards we visited, we did not identify any major environmental risks or hazards.
- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse.
- Medicine storage was secure and accurate logs and records maintained.
- Since the last inspection, the service had achieved JAG Accreditation for their endoscopy services.
- Patients' nutritional status and dietary needs were assessed using a recognised assessment tool.
- Between September 2015 and August 2016, patients at the trust had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions.
- Multidisciplinary team (MDT) working was established on the medical wards. We saw good examples of MDT working on all of the wards and units we visited.
- Staff offered kind and considerate care to patients and those close to them. We saw that for most patients, privacy and dignity was maintained and that most patients' needs were appropriately met. Staff actively involved patients and those close to them in all aspects of their care and treatment. Patients felt included and valued by the staff team.
- Patients and those close to them understood their treatment and the choices available to them.
- Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were sensitive and compassionate in supporting patients and those close to them during difficult and stressful periods.
- Between October 2015 and September 2016 the average length of stay for medical elective patients at trust was 4 days, which is similar to England average of 4.1 days.

Medical care (including older people's care)

- Between December 2015 and November 2016 the trust's referral to treatment time (RTT) for admitted pathways for Medical services has been about the same as the England overall performance.
- In geriatric medicine, the service was above the England average for admitted RTT (percentage within 18 weeks).
- The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others
- The trust's staff in all areas knew and understood the vision, values and strategic goals.

Are medical care services safe?

Inadequate

We rated safe as inadequate because:

- The trust had not responded appropriately to the risk expressed to them at our last inspection regarding the security of patients' records. Across the medical division in all areas we visited, except A11, records trolleys were unlocked. We were advised by the Trust that a decision had been made to keep records unlocked to ensure easy access to the records. Whilst the records trolleys were located at the front of nursing stations, we observed that these areas were not always manned therefore representing the same risk.
- In 32 records we reviewed we found gaps in the frequency of bed rails assessments, falls risk assessments and in three instances bed rails were in place but no risk assessment had been undertaken.
- During our inspection, we identified an issue with the trust's mandatory training recording and reporting system. This meant that some nurses did not have assigned to them, so they had not been provided with the relevant training they should have had.
- There were significant gaps between the trust's target and current levels of staff members' mandatory training completion in some subjects including adult life support and resuscitation.
- Incident reporting categorisation was not the same for similar incidents resulting in incidents not receiving the same level of scrutiny.
- The approach to assessing and managing day-to-day risks to people who use services was sometimes focused on clinical risks and did not consistently take a holistic view of people's needs.
- Safeguarding training levels for staff were not in accordance with the trust's own policy or best practice guidance.
- Services were not consistently delivered in a way that focused on a person's holistic needs.
- There were high vacancy rates (17.4%) for nursing and medical staff within the service. Agency and bank nurses and locum doctors routinely filled gaps in shifts and rotas. This led to an insufficient skill mix of staff in most areas.

- Wards were not adequately staffed at the time of our inspection. Shift fill rates showed that over one quarter of shifts were not filled by either trust or agency staff. The reliance on bank and agency staff on some wards and departments meant that this was not a sustainable position.
- Staff were frequently moved from their usual area of practice to fill gaps in rotas. This resulted in staff being placed in areas where they felt they did not have the necessary skills and competence to meet the needs of patients in these areas.

However:

- Staff understood their responsibility to report incidents.
- Staff were aware of the duty of candour and their obligations regarding this.
- All areas we inspected were visibly clean and tidy.
- Throughout our inspection, in most wards we visited, we did not identify any major environmental risks or hazards.
- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse.
- Medicine storage was secure and accurate logs and records maintained.

Incidents

- Staff understood their responsibility to report incidents, provided us with examples of the type of incidents they would report and explained that they were encouraged to do this. The hospital used an electronic incident reporting system that triggered an email to senior staff to alert them to an incident once a staff member had reported it. Staff told us that learning from incidents was disseminated through emails, communication files, newsletters and at daily meetings. However, senior staff told us that when they incident reported staffing concerns they did not get feedback and the situation did not change.
- There were no never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all health care providers.
- In accordance with the Serious Incident Framework 2015, the trust reported 53 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England between February 2016 and February 2017. The trust undertook trend analysis approximately six months after serious incidents were reported, for example their December 2016 report covered trends from incidents in October 2015 – March 2016. This meant there was no real-time overview of trends as the review was delayed.
- From February 2016-February 2017 there were 4916 incidents reported across the medicine division. 54.9% of these were low or no harm incidents, which is below the average of this type of incident across similar organisations.
- We reviewed all the summaries of incidents for the 4916 incidents reported in the medical division. We noted inconsistency in the grading of incidents, for example a clostridium difficile (c.diff) infection was categorised as minor, moderate and major. We requested the incident grading criteria and this confirmed that the categorisation should have been major. The data had not been amended by the senior staff reviewing the incidents or the governance team. This also meant the data for the number of serious incidents was inaccurate, as the error in the reporting had not been identified.
- The trust's incident grading criteria did not mirror across to general incident grading criteria used in other NHS organisations, for example the trust did not use no or low harm categorisation instead using 'moderate' as a categorisation for minor incidents. This left the trust open to mistakes in incident reporting categorisation particularly by bank and agency staff which the trust heavily relied on.
- Staff reported 431 incidents in relation to staffing concerns within the medical division. At the time of our inspection the trust did not hold regular morbidity and mortality meetings within the medical division. Senior staff told us that there was no set criteria for mortality reviews in the medical division and that approximately 5% of deaths were reviewed by individual groups. There was no process identifying who learning should be shared with or the frequency that meetings should be held. We requested meeting minutes but were informed these were not kept. This is not in accordance with best practice and recommendations in national guidance. However, in January 2017 the trust had arranged for independent consultants and the Medicine Business

Group Associate Medical Director to review deaths as a one off that fit the National Confidential Enquiry into Patient Outcome and Death grading criteria and health round table grading criteria.

- The trust told us they had recently reviewed the process to make these improvements. We requested meeting minutes, but received the report that was reviewed at the meeting. Whilst this was comprehensive, we were unclear who attended this meeting and how lessons learnt were shared with the wider medical team.
- Staff we spoke with advised that they were encouraged to be open and honest with patients.
- Staff we spoke with understood the duty of candour. Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on a registered person who must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis through the nursing dashboard.
- Safety thermometer information for medical services showed that from April 2016 to February 2017 the trust had reported 21 avoidable pressure ulcers, , 34 falls with harm and 17 catheter urinary tract infections between December 2015 and December 2016. We requested up to date data at the time of our inspection but did not receive this at the time of reporting.
- This year's target for avoidable falls across the trust is 19 or below. In February, there were two patients who had a fall. One of these falls was still under investigation. Across the trust there have been 44 falls graded major and above between April 2016 to the end of February 2017. 37 falls have occurred in medicine. There had been seven avoidable falls, which had occurred on B2, E2, C2, A11, AMU1, the transfer unit and A10. 31 falls out of the 44 were deemed unavoidable. Seven falls were still under investigation. To date the trust is on target to meet its trajectory for 2016/17.
- The trust was working to achieve stretch targets for pressure ulcers. A stretch target is a target that pushes the limit beyond what was previously achieved. The stretch target for Stockport Acute services is zero tolerance of avoidable pressure ulcers grade 3 and 4 by the end of 2017. In February, there had been two category three and above pressure ulcers reported for acute services, both of which were deemed avoidable. The total avoidable pressure ulcers this financial year was 21 at the time of our inspection. The number of new pressure ulcer incidents and the severity being reported within the acute trust had decreased significantly in February by more than 50% (new pressure ulcer incidents reduced from 30 to 14.
- The safety cross was monitored via the nursing dashboard with subsequent action plans developed. The action plans were monitored on a monthly basis by the quality governance board.
- Safety thermometer results were displayed on the wall at each ward entrance. This was to inform members of the public and promote staff understanding.
- Results and any relevant actions were discussed at ward meetings.

Cleanliness, infection control and hygiene

- Monthly infection control audits were undertaken across all wards, which looked at standards such as the cleanliness of patient equipment. We reviewed the infection prevention audits. Overall, across all wards in the medicine division the audit findings were below the trust's target of 95% compliance. In the clinical practice audit, the medicine business group's average was 67%. In the environment practice's audit, the medicine business group's average was 69%. The overall audit for the medicine business group's average was 68%. We requested an action plan, which outlined actions to be taken, how this was to be actioned and an estimated completion date.
- Monthly hand hygiene audits were undertaken by staff being observed. Results for the hand hygiene audit from October 2016 to February 2017 across the medicine division averaged 79.4%, which was below the trust's target of 90%. The trust had an action plan in place to address these issues.
- From October 2016 to February 2017, the cannula care audit averaged 80.4%, which was below the trust's target of 90%.

- Infection prevention and control staff training figures were 90% for level one training and 87% for level two training, which were both below the trust's target of 95%.
- In our records review we found 11 sets of patients' records where both MRSA and stools chart assessments were between 13 hours and 4 days late. This represented a patient safety issue which was escalated to the trust at the time of our inspection. At the time of our inspection, most areas we inspected were visibly clean and tidy. However, during our inspection we found several commodes in clinical areas that were still in use. These commodes had large sections of cracked plastic coating were patients' hands would be positioned thus representing an infection control risk. We escalated this issue at the time of our inspection.
- Between April 2015 and December 2015 medical services reported no cases of clostridium difficult, methicillin-resistant staphylococcus aureus (MRSA) or methicillin-susceptible staphylococcus aureus (MSSA). We requested an update in this information from the trust, but at the time of reporting had not received it. However, the medicine business group meeting minutes stated there had been no cases of MRSA since April 2016 and 5 cases of c.diff in February 2017.
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use. Staff we spoke with understood this labelling system. However, the 'I am clean' stickers we observed were not dated or signed.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Most sharps containers were dated and signed on assembly. However, the temporary closure was not used in all areas we visited when sharps containers were not in use.
- We saw evidence that staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.
- Hand gel and personal protective equipment was accessible on each ward and was utilised by staff and visitors.
- Patient led assessments of the environment (PLACE) between February and June 2016 showed a standard of 98.3% in the trust for cleanliness, which was in line with the England average.
- Side rooms were used as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- Cleaning schedules were in place and had been completed as required, therefore reducing the risk of cross infection.

Environment and equipment

- Throughout our inspection, in most wards we visited, we did not identify any major environmental risks or hazards. However, in the acute medical unit (AMU) we found two tubs of fluid thickening agent that were in close proximity to patients. All hospitals had received an alert that fluid thickening agents should be kept in a locked area away from patients. The presence of the fluid thickening agent represented an immediate patient safety risk, which we escalated at the time of our inspection.
- On the AMU the sluice room was unlocked at the time of our inspection. We escalated this at the time of our inspection because there were toxic substances in the room that were not stored within the trust's lockable cupboard.
- At the time of our inspection the resus trolley on the Coronary Care Unit (CCU) and Short Stay Older People's (SSOP) unit were not locked.
- Each ward had designated toilets and showers for male and female patients. However, on one ward we visited male patients had to walk through the female part of the ward in order to access the bathroom. This was because the shower/toilet had been reported as faulty. However, the shower facility being used was also used to store wheelchairs.
- Staff told us that nursing ward A11 could prove challenging in view of the environment and ward layout. We observed that there were not clear lines of sight to patients. During our inspection, we observed that two patients had absconded from the ward. Staff told us that due to staffing levels at that time and the ward environment, it was felt the patients may have been

missing for longer than they suspected as they were not seen leaving the unit. Senior staff told us that the acuity tool did not take into consideration the ward environment.

- The hospital has been higher than the England average for the Patient-Led Assessments (PLACE) from 2013-2016.
- Equipment was routinely maintained and serviced. Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated daily checks of the equipment took place on all of the wards and units we visited. This meant there was emergency equipment available and in date when required.
- The hospital had a quality management system in place that complied with ISO 9001:2008 in relation to asset management, maintenance and repair of medical equipment. The ISO 9000 standards are designed to help organisations meet statutory and regulatory requirements related to equipment.
- Records showed equipment was routinely maintained in accordance with manufacturers' guidance including portable appliance testing (electrical equipment).

Medicines

- The trust undertook controlled drug (CD) spot check audits. These audits reviewed two medicine wards and showed across both wards the record of receipt of CDs were completed on 60% of occasions. The trust's target was 100% compliance. Across both wards the record of receipt of CDs in the CD record book were completed on 70%-80% of occasions. This was below the trust's target of 100%. We requested an action plan outlining how the trust was addressing this issue. The trust told us they had not created an action plan to address the audit's findings, despite the latest audit being on 1 March 2017 and our data request being made at the end of March 2017.
- Nursing care indicators outlined that there were eight medication incidents involving nursing staff in February 2017, which was above the trust's target.
- Suitable cupboard and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. We sample checked medicines on the wards and in most instances found them to be in date, indicating there were stock management systems in place. However, on A1 there were medications in use without opened dates and a limited supply that were out of date.
- We looked at the prescription and medicine records for 15 patients. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed. Allergies were clearly documented. The trust's audit also confirmed these findings.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were completed on the wards we visited. Staff were able to tell us the system identified to follow up if there were gaps in these records.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately on the wards we visited. Access was limited to qualified staff employed by the trust. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient.
- Emergency medicines were available for use and records indicated these were regularly checked.
- Patients were provided with a lockable drawer or cupboard in which to store their medication.
- A member of the trust's pharmacy team visited medical wards regularly. Pharmacy staff checked that the medicines patients were taking when they were admitted to the wards were correct and that records were up to date.
- Staff within the hospital had a clear guidance document in place that explained the procedure regarding medication to them when they discharged patients to the community unit.

Records

- The hospital used electronic and paper based patient records across the medicine division.
- During our last inspection we identified that the records trolleys that were inspected were unlocked which meant they were potentially accessible by members of the public. During this inspection in all areas, except A11, records trolleys we visited were unlocked. Whilst the records trolleys were located at the front of nursing stations, we observed that these areas were not always manned therefore representing the same risk.

- Records showed that most patients had their needs assessed on admission to hospital and care plans were created with review dates.
- Records audits were undertaken to review compliance with the trust's record policy. We reviewed the trust's record keeping audits for the last two quarters. The October 2016 audit showed 40% compliance with the trust's record keeping policy. The key gaps were in the areas we identified during our inspection. The November 2016 audit showed 73% compliance with the trust's record keeping policy. December's audit showed 75% compliance, which is defined as an acceptable level by the trust. January's audit showed 100% compliance despite there being short falls identified within the audit. However, February's audit showed 33% compliance with the trust's record keeping policy. The overall compliance rate for October-December 2016 was 55%, which was a significant decrease in compliance from that at our last inspection and the previous quarter's figures (91% compliance). We requested details how the trust were addressing these issues but had not received this at the time of reporting.
- During our inspection we reviewed 24 complete (paper and electronic) patient records, 12 paper based patient records and a further 32 sets of electronic records.
- We reviewed 56 sets of electronic records. In 17 sets of records the observations were recorded as between one hour and seven days late. All 56 records showed that intentional rounding observations were between 54 minutes and 12 days late. The average delay in completion of these records was that they were 1.5 hours late. Intentional rounding is a structured process where nurses on wards in acute and community hospitals and care home staff carry out regular checks with individual patients at set intervals, typically hourly. During these checks, staff carried out scheduled or required tasks. 10 sets of records showed MRSA and stools chart assessments were between 13 hours and 4 days late. When discussing this issue with staff they advised that due to the situation with nurse staffing, completion of paperwork was the first thing that was impacted upon. We escalated these issues at the time of our inspection.
- On one ward we reviewed all 12 patients' paper based records and they were particularly poor. There were two missing observation charts, three missing fluid balance charts, one pressure ulcer risk assessment was out of date, two DNACPR forms were not fully completed, capacity assessments had not been undertaken for patients that lacked capacity and the records generally were not comprehensively completed. Notes lacked evidence of regular MDT involvement. We escalated our concerns regarding this at the time of our inspection for immediate action.
- Mental capacity assessments were not evidenced in 9/10 patients' records for patients who should have been assessed for their care to be in line with the trust's policy. In one case we observed nurses restricting a patient from leaving the ward when there was no capacity assessment or DoLs application in the patient's records.
- In three records we reviewed student nurses' signatures were not countersigned, which is not in accordance with best practice. The trust had had a serious incident in 2016 where countersigning student nurses' notes had been identified as a concern, but at the time of our inspection this had not been resolved.
- In 32 out of 36 records we reviewed we found gaps in the frequency of bed rails assessments, falls risk assessments and in three instances bed rails were in place but no risk assessment had been undertaken. Patient information boards provided, at a glance, an overview of patients and the public.
- Patient information boards did not respect patient confidentiality as they were visible by the key risks, medication and discharge plans for each patient.
- During our inspection we observed that four out of five do not attempt cardiopulmonary resuscitation (DNACPR) forms were not comprehensively completed. We escalated this to the provider at the time of our inspection. At the time of our unannounced inspection this issue had been addressed.
- Records were legible, signed and dated. However, staff members' names and designation was not always clear or printed, which is not in accordance with best practice guidance on record keeping outlined by the GMC and NMC. This was particularly important as nursing and medical records were written on the same continuation sheets.
- The nursing records on the AMU had full assessments completed including MUST, waterlow, falls and pressure ulcer documentation.

Safeguarding

- During our inspection we identified a concern with the trust's mandatory training recording and reporting

system. This meant that some nurses did not have competency requirements assigned to them, so they had not been provided with the relevant training they should have had. It also meant that in terms of reporting, senior managers had no true oversight of the mandatory training levels for nursing staff. For example on one ward 50% of the nursing staff had not been allocated the competency for Mental Capacity Act and DoLs training. These staff were not showing on the trust's database as requiring the training so the records did not show they had not completed it. We escalated this issue at the time of our inspection and were informed the issue was not limited to one ward or mandatory training subject and that it would be fully investigated. This meant that the trust's safeguarding figures provided were the highest they could be, but they may actually be lower than those reported below.

- The trust target for safeguarding compliance was 95%. At the time of our inspection across the medicine division 79.8% of staff had completed their safeguarding vulnerable adult's level one training and 82.5% of staff had completed their level two safeguarding vulnerable adults training. This was not in accordance with best practice outlined in the intercollegiate guidance. The trust did not have an action plan to address thee shortfalls but did review training records at a monthly meeting.
- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team, which provided guidance during the day in the week. Staff had access to advice out of hours and at weekends from the hospital on-call manager.

Mandatory training

- During our inspection we identified a concern (outlined above under safeguarding) with the trust's mandatory training recording and reporting system, which was escalated to the trust at the time of our inspection. This meant that the trust's mandatory training figures provided were the highest they could be, but they may actually be lower than those reported below.
- The trust target for mandatory training compliance was 95%. In January 2017 across the medicine division training compliance was 85.1%, which was below the trust's target of 95%. Areas of concern included 'safe use of insulin' (80.5%), equality and diversity (82%), information governance (83.4%), conflict resolution (50%), resuscitation (76.5%), adult basic life support (61%), blood transfusion (77.4%) and venous thromboembolism (75.8%). We asked for amended data to reflect our findings on inspection, but did not receive this.
- Staff confirmed they had a corporate induction on commencing work and this induction also included temporary staff.
- Annual mandatory training included infection control, fire safety, information governance and safeguarding.
- Staff told us they received electronic reminders to attend training and were given the time to attend.
- Staff we spoke with were aware of the trust's sepsis policy.

Assessing and responding to patient risk

- During our inspection, we saw evidence that upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways, and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST). However, these assessments were not consistently reviewed and updated on the medical wards. In 32 records we reviewed we found gaps in the frequency of bed rails assessments, falls risk assessments and in five instances bed rails were in place but no risk assessment had been undertaken.
- We saw evidence that electronic early warning scores (EWS) were completed to identify patients who were at risk of deteriorating. The computer system would automatically calculate the observation period required depending on a patient's observations e.g. pulse, temperature etc.
- We reviewed 56 sets of electronic records. In 17 sets of records the observations were recorded as between one hour and seven days late. Staff explained that this was because of the nurse staffing situation, which breached the trust's guidance on staffing. For example, on one ward we visited there was one qualified nurse to 11.5 patients. On another ward we visited there was one nurse to 13 patients.
- On ward A12, where the computer indicated there were delays in observations between 3 and 7 days, staff explained that the computer system did not work there so paper based records were used. These records did

not have the same trigger points as the electronic system and no EWS chart for interpretation purposes was readily available. A EWS chart sets out the parameters when a patient's observations indicate further action should be taken. This represented a patient safety risk, which we escalated at the time of our inspection.

- On ward A12 care was not delivered in a way that focused on a person's holistic needs. Call bells were out of reach, which represented a patient safety issue as patients were unable to call for assistance.. An inspector had to intervene to stop one patient from falling.
- In the Coronary Care Unit (CCU) the telemetry monitors were not continuously observed. Staff explained that patients also had alarms set to alert them if patients' observations went outside the parameters they had set. We escalated our concerns regarding this patient safety issue at the time of our inspection.
- Staff told us that 99% of patients were seen and assessed by a consultant within 12 hours of admission or within 14 hours of their time of arrival at hospital. The trust told us that they do not record and audit this information, which is against best practice and the trust's Commissioning for Quality and Innovation (CQUIN) national goals.
- Records we reviewed showed the escalation process had been follow appropriately when required.
- Records we reviewed confirmed patients were regularly reviewed.

Nursing staffing

- The service used the Safer Nursing Care Tool to measure staffing levels. However, this tool did not take into consideration the environment and layout of wards. On ward A11, there were several areas where there was no line of sight from the nursing station or other bays. At the time of our inspection there were two nurses and three HCAs on duty, when there should have been three nurses and four HCAs. Two patients had absconded without being observed, one of which was on a DoLs. Ward staff had taken appropriate action once they discovered the patients had absconded, but steps had not been put in place to address the staffing issue until we escalated this to the trust.
- During our inspection, on all the wards that we visited there was one to two nurses less per shift. Senior nursing staff told us that patient care was compromised when staff were taken away from the wards. On one ward during our inspection there was one registered nurse to 10.5 patients. On another ward, there was one registered nurse to 13 patients. Staff explained they incident reported this situation every day and nothing was done about it. Staff told us the impact on patient care is that falls assessments and risk assessments are not completed as priority has to be given to direct patient care and the provision of medication. We reviewed 426 incident reports and they confirm a direct impact on patient care as a result of the staffing situation.
- Staff on the coronary care unit (CCU) looked after patients who needed level one and level two care. They assessed the acuity of the patients on a regular basis to determine if they were level one or level two patients. This was done to ensure appropriate skill mix of staff. Level two patients require higher levels of care and more detailed observation and intervention. However, staff told us that the unit was continually staffed by two nurses. This meant staff were unable to leave the unit during their breaks.
- We reviewed incident reports for the CCU and noted that on 26 occasions between February 2016 and February 2017 the unit was inappropriately staffed. The incident reports outline direct evidence of impact on patients and patient safety concerns.
- On the SSOP unit, a ward we observed several staff moves on during our inspection, 66 staffing incidents had been reported between February 2016 – February 2017
- Senior nurses who were supernumerary (in addition to the planned number of nurses so they could oversee the running of the ward and assist where necessary) said they often completed shifts due to shortage of staff due to short notice sickness. This meant management tasks were often left uncompleted.
- We noted that nursing staff were moved mid-shift and decisions were made to do this by different senior nurses based on their clinical judgment. There was no set criteria to benchmark this decision against.
- During our inspection we noted that some nurses were moved multiple times in a shift. Whilst each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered, the off duty rotas did not consistently reflect what staff were on a shift as

moves mid-shift were not always documented in the off duty rotas we reviewed. The trust could therefore not tell us with any degree of accuracy how many nurses were on a ward at a specific point in time.
- Nursing staff told us that they had an induction and a supernumerary period. However, they were not consistently permitted to be supernumerary as staffing levels did not always permit this.
- The trust told us that it could not tell provide us with the number of patients that were on a ward at a point in time. This meant there was no mechanism for ensuring staffing numbers were safe.
- For 2017 the percentage of shifts filled (by trust staff, temporary and agency staff) ranged between 26% and 82% (average 65%) in January 2017, 32.7% and 88.79% (average 74%) in February 2017 and 35% and 88.8% (average 74%) in March 2017. Particular areas of concern included the coronary care unit (CCU). From October 2016 to March 2017 the percentage of unfilled shifts ranged from 29.5% to 57.5% with an average of 47.6% unfilled shifts.
- We reviewed staffing figures for March 2016 to February 2017. Most medical wards were below the national benchmark of 80% during the day and night. In January 2017, one out of 19 medical wards was above the benchmark, in February 2017 three out of 19 medical wards were above the benchmark and in March 2017 two out of 19 medical wards were above the benchmark.
- We reviewed the use of agency and bank nurses between January 2017 and March 2017 and found that all medicine wards regularly used temporary staff. Figures showed temporary staff usage consistently exceeded 29% across all wards. Particular areas of concern were the acute medical unit, A11 (acute medical ward), B2 (medical ward) and A3 (cardiology unit) were temporary staff usage consistently exceeded 50%.
- In December 2016 there were 17.3% staff vacancies across the medicine division. This meant there were 208.7 whole time equivalent (wte) staff vacancies.
- The staff turnover rate was 17.6% from February 2016 – January 2017. This was above the trust target of 4%.
- The appraisal rate for the medicine division was 89.7%, which was below the trust's target of 95%.
- The sickness rate across the medicine business group in January 2017 was 3.7%, which was below the trust's target of 4%. From January 2016 – January 2017 the sickness rate averaged 4%, which was in line with the trust's target.
- Medical wards displayed nurse staffing information on a board at the ward entrance in line with guidance contained in the Department of Health document 'Hard Choices'. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- The service used the trust escalation procedures if there was a reduction in the number of nursing staff of duty. This included undertaking a risk assessment and escalating the issues to the 1090 bleep holder.
- Nursing handovers were structured and information handed over to the incoming staff included allergies, mobility of patients, incidents and expected date of discharge. Each member of staff on the ward had access to a copy of the handover sheet at the beginning of each shift.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across all wards. All medical trainees contributed to this rota.
- There was an on call rota which ensured there was a consultant available 24 hours a day seven days a week for advice. The trust told us that a medical consultant is contactable during week days on a bleepfrom 09:00 to 19:00. Beyond thatan on call consultant is on site till 10pm and available through switchboard. At weekends there is a constant consultant presence on the Acute Medical Unit (AMU) until 20:00. AMU is in close proximity to the emergency department. After 20:00 at weekends and 22:00 on weekdays a consultant is available via switchboard and if needed will be present within 30 minutes to one hour.
- Some wards had developed a consultant of the week system, which staff felt was particularly beneficial for patients and patient flow. However, we observed that this system was not in place on the coronary care unit, an issue the trust were addressing.

Medical care (including older people's care)

- In September 2016, the proportion of consultant staff reported to be working at the trust were about the same as the England average (32% vs 37%) and the proportion of junior (foundation year 1-2) staff was lower (13% vs. 20%).
- In December 2016 there were 17.4% staff vacancies across the medicine division. The staff turnover rate was 17%. This was above the trust target of 4%.
- We observed two ward rounds which were attended by the consultant as well as junior doctors and nurses. There was effective verbal communication between each other and the patients.

Major incident awareness and training

- Senior staff told us there was a business continuity plan and major incident plan.
- Staff were able could access the major incident policy via the intranet.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not demonstrate a good understanding of the trust's policy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs).
- There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation. Decision-makers did not always make decisions in the best interests of people who lack the mental capacity to make decisions for themselves, in accordance with legislation. Restraint and deprivation of liberty were not always recognised, or less restrictive options used where possible. Applications to authorise a deprivation of liberty were not always made appropriately or in a timely manner to the Court of Protection or by using the Deprivation of Liberty Safeguards.
- Mental capacity assessments were not evidenced in 9/10 patients' records for patients who should have been assessed for their care to be in line with the trust's policy. In one case, we observed nurses restricting a patient from leaving the ward when there was no capacity assessment or DoLs application in the patient's records.
- Staff had access to the materials they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records. However, because nursing intervention records were not consistently completed and reviewed, the information available within records was not comprehensive.
- From January 2017 – March 2017 87.9% of patients' discharge summaries were published within 48 hours. This was below the trust's key performance indicator of 95%.

However:

- Since the last inspection the service had achieved JAG Accreditation for their endoscopy services.
- Patients' nutritional status and dietary needs were assessed using a recognised assessment tool.
- Between September 2015 and August 2016, patients at the trust had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions.
- Multidisciplinary team (MDT) working was established on the medical wards. We saw good examples of MDT working on all of the wards and units we visited.
- The trust had a process in place for assessing its compliance with NICE guidance.

Evidence-based care and treatment

- The trust told us that all National Institute for Health and Clinical Excellence (NICE) standards are monitored through the trust's software by business group leads. For the medicine business group the primary link is the governance and quality manager supported by the governance administrator. As and when new NICE documents were shared these get added to the software. The documents were then reviewed and shared with the relevant clinical director or clinical speciality lead for review and opinion regarding compliance.
- NICE compliance is a regular agenda item within the monthly medicine business group quality governance board. Reports are reviewed at monthly business group executive performance review meetings. They are also reviewed on a monthly basis at the trust wide quality governance committee.
- We requested evidence of compliance with NICE guidance. The trust's records showed that they were compliant with 45 relevant guidelines including CG181

(Updated Sep) Cardiovascular disease: risk assessment and reduction including lipid modification, CG126 (Updated Aug) Stable angina: management, NG049 Non-alcoholic fatty liver disease (NAFLD): assessment and management, CG152 (Updated May) Crohn's disease: management, NG039 Major Trauma: assessment and initial management and NG040 Major Trauma: service delivery. In a further 37 areas, the trust were mostly compliant (9), partially compliant (5), had an assessment in progress (14) or have not yet assessed compliance (9). The areas were assessments had not yet been made were all from 2017 and included QS086 (Updated Jan) Falls in older people, QS143 Menopause and QS144 Care of dying adults in the last days of life.

- The Trust participates in both National and Local clinical audit activity. The trust used their computer system to capture the clinical audits.
- The trust has registered for the National audit of inpatient falls (NAIF) for 2017. Data will be inputted between 15 January to 2 June 2017.
- The trust told us each business group held quarterly clinical audit & quality forum meetings where the findings from audits were shared and the recommendations were discussed. Following the meeting the action plan was created, logged and then implemented. If there were issues with the timescales of actions being completed this was fed through the business group quality board.
- Nursing care indicators were used across the medicine division. In September 2016 nursing care indicators were at 97.7% overall for the medicine division, before a deterioration to 94.4% in November 2016. The figure steadily improved to 95.6% in January 2017. In February 2017 the division were achieving 95.3% overall. This was above the trust's overall target of 95%.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored. Patients told us they were consistently asked about their pain and supported to manage it.
- We saw that patient's pain levels were recorded on early warning scores records.

Nutrition and hydration

- Patients' nutritional status and dietary needs were assessed using a recognised assessment tool.
- Specialist dietary support was available to patients who required a particular or individualised diet.
- Specialist support was available from the speech and language team to support patients who experienced difficulty with eating and drinking.
- Staff were sensitive in assisting patients to eat and drink where required.
- Patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal, as they were not on the ward at the time, staff were able to order a snack for them.
- We saw drinks were available and in reach for most patients.
- Fluid balance charts we inspected were not comprehensively completed and appropriately maintained.
- Wards had protected meal times. However, staff told us that they could use discretion regarding this to allow relatives to help with eating and drinking as per individual need or request.

Patient outcomes

- Between September 2015 and August 2016, patients at the trust had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions. Of the top three specialties for elective admissions, only Geriatric Medicine had a slightly higher relative risk of readmission. For the top three specialties for non-elective admissions, Cardiology was the only specialty with a higher than expected relative risk of readmission.
- The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, March 2017. This is an improvement in rating from the previous audit and is better than the England average of a D rating.
- The trust's results in the 2015 Heart Failure Audit were better than the England and Wales average for two of the four of the standards relating to in-hospital care – received echo, and input from specialist. For the remaining two standards, cardiology inpatient and input from consultant cardiologist, the trust scored lower than the England average.

Medical care (including older people's care)

- The trust's results were better than the England and Wales average for five of the seven standards relating to discharge. The two standards they scored lower than the England average on were Referral to HF nurse for follow up and Referral to cardiology for follow up.
- The trust took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in nine metrics and worse than the England average in eight metrics. The indicator regarding "foot risk assessment during stay" had the largest difference versus the England average with 26.1% more patients receiving an assessment in Stockport.
- The trust took part in the 2013/14 MINAP audit and scored worse than the England average for all of the three metrics. Performance had remained similar to the 2012/13 audit. We requested updated information but at the time of reporting had not received it.
- The trust participated in the 2015 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 78.9%, which was worse than the audit minimum standard of 80%. The 2014 figure was 86.4%.
- The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 28.4%, this is not significantly different from the national level. The 2014 figure was 25%.
- The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 61.3%, this is not significantly different from the national level. The 2014 figure was 43.3%.
- The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 82.6%, this is not significantly different from the national level. The 2014 figure was 80%.
- The JAG Accreditation Scheme is a patient centred and workforce focused scheme based on the principle of independent assessment against recognised standards. The endoscopy service at the trust was level one JAG accredited in March 2016. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy GRS Standards.

Competent staff

- Staff told us they received appraisals that supported them in their role and professional development. However, the appraisal rate for the medicine division was for February 2017 was 89.7%, which was below the trust's target of 95%.
- Staff told us that they were given access to development within their roles and were given time to access courses.
- Link nurses attended relevant training and cascaded this at ward level. For example staff caring for patients suffering from diabetes had received training from Link nurses to their wards that enabled them to manage patient care more effectively. Staff also told us they could access link nurses for support with specific patients when needed.
- New guidelines from the Royal College of Physicians had been circulated for taking lying and standing blood pressure. These will be incorporated into the revised training programme.
- The trust had introduced an improving wound care diploma devised and agreed by the newly formed Wound Care Steering Group, chaired by the district nursing service.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on the medical wards. We saw good examples of MDT working on all of the wards and units we visited. This included nursing staff as well as therapy staff such as a physiotherapists and specialist nurses.
- All medical records we reviewed showed appropriate MDT involvement.
- Ward teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.
- Daily ward meetings were held on most of the wards we visited. These were called board rounds or safety huddles and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge.
- Patients were referred to community services if they required ongoing aftercare.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- Operating services for stroke patients were available 16 hours per day seven days a week.

Medical care (including older people's care)

- Staff told us that services such as physiotherapy and SALT were routinely available five days a week. At weekends physiotherapy and SALT access could be obtained for urgent cases.
- Staff told us and we saw evidence that patients in high dependency areas were reviewed by a consultant twice daily. The trust was rolling out a consultant of the week model across the medicine works to promote continuity of care. However, the trust told us that on the coronary care unit there were concerns with this system because some consultants only saw their own patients. The trust was addressing this issue.
- Patients' records evidenced daily medical ward rounds.

Access to information

- Staff had access to the materials they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records. However, because nursing intervention records were not consistently completed and reviewed, the information available within records was not comprehensive.
- There were computers available on the wards we visited, which staff accessed for patient and trust information. Policies, protocols and procedures were kept on the trust's intranet, which meant staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits, which were available to staff.
- Patients were discharged from hospital with a copy of their discharge summary. This was also forwarded to the patient's GP and contained a summary of care provided along with medications patients were discharged with. From January 2017 – March 2017 87.9% of patients' discharge summaries were published within 48 hours. This was below the trust's key performance indicator of 95%. The trust told us that they had recruitment plans in place to improve performance in this area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not demonstrate a good understanding of the trust's policy regarding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs). We spoke with 39 members of staff and none of them were able to describe the correct process, outlined in the trust's policy, to undertake mental capacity assessments.
- Mental capacity assessments were not evidenced in 9/10 patients' records for patients who should have been assessed for their care to be in line with the trust's policy. In one case we observed nurses restricting a patient from leaving the ward when there was no capacity assessment or DoLs application in the patient's records. Of 10 records reviewed, one record showed that the policy had been correctly followed. We escalated this issue to the trust at the time of our inspection.
- Not all staff we spoke to on the wards knew that the use of bed rails can be a form of restraint as outlined in the Royal College of Nursing (RCN) rights, risk and responsibilities guidance.
- Most staff had the appropriate skills and knowledge to obtain consent from patients. Most staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. We saw written records that indicated consent had been obtained from patients prior to procedures or treatment. However, on one ward we saw evidence of four patients with confusion whose capacity was questionable at the time the consent had been given. No capacity assessment had been undertaken.

Are medical care services caring?

Good

We rated caring as good because:

- Staff offered kind and considerate care to patients and those close to them. We saw that for most patients, privacy and dignity was maintained and that most patients' needs were appropriately met. Staff actively involved patients and those close to them in all aspects of their care and treatment. Patients felt included and valued by the staff team.
- Patients and those close to them understood their treatment and the choices available to them.
- Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were sensitive and compassionate in supporting patients and those close to them during difficult and stressful periods.

However:

- Due to staffing pressures patients' dignity was not consistently maintained.

Medical care (including older people's care)

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed numerous examples of compassionate care provided to patients. There was a positive rapport between patients and staff.
- Staff treated patients with dignity and respect. However, on one ward a female patient, who was nursed in close proximity to a male bay, was completely exposed at the time of our inspection. We escalated this to the trust. We revisited the ward and found that the patient was partially exposed. We escalated this to the trust again. On our unannounced inspection this patient had been moved to a side room and was appropriately covered.
- We spoke to 17 patients throughout our inspection. Most patients we spoke with were positive about their care and treatment.
- On most wards people had access to call bells and staff responded promptly. However, on the AMU and A12 patients did not have their call bells within reach. We escalated this at the time of our inspection.
- Staff maintained patients' confidentiality.
- The Friends and Family Test response rate for Medical care at trust from February 2016 to February 2017 was 45.3%, which was better than the England average of 25% . However, in the nursing care indicators data submitted the response rate for February 2017 was 30.8%.The trust told us this data would not match the figures shown by the ward dashboard due to escalation wards being included in the trusts total but not in the nursing dashboard. All wards had an average recommendation rate of more than 90%.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of this, and on the wards we visited, the relevant names were displayed on a board above the bed. Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- The patients and most relatives we spoke with told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. Most relatives felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.
- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with personal care and supporting patients to eat at meal times.

Emotional support

- Meeting people's emotional needs was recognised as important by all staff disciplines, and staff were sensitive and compassionate in supporting patients and those close to them during difficult and stressful periods.
- Patients had access to emotional and psychological support from nurses specialising in cancer, heart failure, diabetes, pain relief and safeguarding.
- We observed staff offering emotional support and listening to patients' and families concerns in a helpful and reassuring way.
- The chaplaincy and spiritual service was also available for spiritual, religious or pastoral support to those of all faiths and beliefs.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Services were not consistently delivered in a way that focused on a person's holistic needs.
- Delayed transfers of care had significantly increased from our last inspection. From January 2017 to February 2017 the trust had an average of 77 patients per day with delayed transfers of care, which was above the trust's key performance indicator of 10 patients per day.
- We observed that leaflets in the hospital were all in English. The trust is located within a Polish and Bangladeshi community. Staff advised us they could be translated, but were not readily available in other languages.

However:

- Between October 2015 and September 2016 the England length of stay for Medical elective patients at trust was 4 days, which is similar to England average of 4.1 days.

Medical care (including older people's care)

- Between December 2015 and November 2016 the trust's referral to treatment time (RTT) for admitted pathways for Medical services has been about the same as the England overall performance.
- In geriatric medicine the service was above the England average for admitted RTT (percentage within 18 weeks).

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of the local population and included national initiatives and priorities. Part of the trust's overall strategy was to focus on the care of older people to better meet the care needs of the local population.
- The facilities and premises in medical services were appropriate for the services that were planned and delivered.
- Engagement with other trusts in the area assisted with planning services for the population and supporting neighbouring trusts. This was the case in the provision of intermediate care for patients before returning to their place of residence.
- At the time of our inspection two patients had absconded from a ward without being seen. One patient was on a DoLs. The patients had been able to abscond without being seen due to there being less staff on duty than the acuity tool required and due to the ward environment. Staff told us the acuity tool did not take into account the environment. The decision to move nurses was made by senior staff using their clinical judgement without any guidance materials.
- The trust had an ambulatory care unit. We requested the standard operating procedure but at the time of reporting had not received it.

Access and flow

- From March 2016 – February 2017 the trust had 89,659 medical admissions including day case admissions. 28,390 of these admissions were from the emergency department. This averaged 7,472 admissions per month and with the exception on November 2016, remained around that average figure month on month.
- Between October 2015 and September 2016 the average length of stay for Medical elective patients at trust was 4 days, which is similar to England average of 4.1 days. For Medical non-elective patients, the average length of stay was 6.4 days, which is similar to England average of 6.7 days. General medicine stays for both elective and non-elective admissions was lower than the England average. Of the top three specialties, only Cardiology had a higher length of stay than the England average with 8.7 days compared to 5.3.
- Between December 2015 and November 2016 the trust's referral to treatment time (RTT) for admitted pathways for Medical services has been about the same as the England overall performance. The latest figures for November 2016, showed 94.7% of this group of patients were treated within 18 weeks versus the England average of 88.9%. Over the last 12 months the trust has seen a mixed performance. From December 2015 to April 2016 the trust was performing better than the England average before performing worse than the England average between May 2016 to October 2016 before seeing an improvement in November 2016.
- In geriatric medicine the service was above the England average for admitted RTT (percentage within 18 weeks). However, two specialities (general medicine and rheumatology) were just below the England average at 95.7% and 95.6%.
- From January 2017 to February 2017 the trust had an average of 77 patients per day with delayed transfers of care. This had increased from an average of 41 patients per day at the time of our last inspection (January 2016) and was above the trust's key performance indicator of 10 patients per day.
- From January 2017 to February 2017 19% of patients were discharged before 12:00.
- We observed the wards we visited had daily 'board rounds.' In records we reviewed there was evidence that discharge planning had been started on admission.
- From 1 April 2016 – 28 Feb 2017 the trust had 5000 medical outliers. A medical outlier is a medical patient that is not in a medical ward during their hospital stay. The average was 15 medical outliers per day.
- We asked the trust to confirm to us the number of time a patient moved during their stay. From March 2016 to February 2017, 20, 344 patients moved once (so were admitted then moved to a different ward), 4872 were moved twice, 1077 were moved three times, 239 were moved four times, 67 were moved five times, 25 were moved six times, 6 were moved seven times, 5 were moved eight times and 4 were moved nine times.
- The service have a transfer unit to facilitate discharges from the hospital.
- The trust had introduced a short stay older people's unit aiming to discharge patients within 72 hours. Staff told

us this had been particularly effective when the service had had seven day access to MDT staff, but weekend discharges had reduced now the service had five-day access to MDT services.
- The endoscopy unit were open from 8am to 10pm Monday and Tuesday and 8am to 6pm on Wednesdays to Saturdays.

Meeting people's individual needs

- The trust had a lead nurse for dementia and a flag system on the electronic record to alert staff so staff could plan patients care accordingly.
- On ward A12 staff told us that they struggled to access MDT involvement on the ward.
- On ward A11 a long-term patient was exposed several times during our inspection and was nursed in close proximity to a male nursing bay. This was escalated and the following day the lady was exposed when we revisited the ward. This did not demonstrate responsiveness or a holistic approach to the patient's care.
- Dementia Awareness training was offered to clinical staff focusing on how dementia affects the brain and how staff can communicate effectively with people with dementia and understanding the realities of the person living with dementia and how best to support them is delivered on a monthly basis. Non-clinical staff were offered 'dementia friends' training which focuses on helping them understand how dementia affects people and provides knowledge on how best to communicate with people with dementia.
- However, the trust averaged 61.2% in the 2016 PLACE assessments for dementia, which was below the England average of 75.3%.
- Between January 2017 and March 2017 96.7% of patients were asked dementia finding questions with 72 hours of admission, which was above the trust's key performance indicator of 90%. Over the same period 92.3% of patients received a dementia assessment and investigation, which was above the trust's key performance indicator of 90%. Over the same period 100% patients had received a dementia referral.
- We observed that wards had appropriate equipment for bariatric patients.
- The trust utilised interpretation and translation services, for patients whose first language was not English.
- We observed that leaflets in the hospital were all in English. The trust is located within a Polish and Bangladeshi community. Staff advised us they could be translated, but were not readily available in other languages.
- All inpatient admissions that had a learning disability were flagged on the electronic record and staff then planned and provided an individualised and appropriate care plan in place.
- The trust had a chaplaincy and spiritual care department. The services were available within working hours and also provided an on-call system seven days a week.

Learning from complaints and concerns

- From March 2016 – February 2017 255 complaints were received across the medical division. The trust responded to the complainant in the agreed timescale 87.5% of the time. Over the same time period, 70.6% of complaints were upheld.
- Monthly performance reports included the response and timeliness of responses and details of complaints partially upheld or upheld by the Parliamentary Health Service Ombudsman (PHSO).
- Staff aimed to resolve complaints locally. PALS information was given to those wishing to forward a complaint.
- Patient advisory and liaison service (PALS) details and leaflets were available on wards and leaflets were available.
- There were examples of practice improving as a result of learning from complaints.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The arrangements for governance and performance management did not always operate effectively.
- Risks, issues and poor performance were not always dealt with appropriately or in a timely way. The risks and issues described by staff do not consistently correspond to those reported to and understood by leaders.
- The approach to service delivery and improvement was reactive and focused on short term issues, for example nurse staffing.

- In view of the expenditure for agency staffing, the sustainable delivery of quality care was put at risk by the financial challenge.
- Some of the information that was used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant.
- We identified an issue with the trust's mandatory training records system that the trust's own governance procedures had not highlighted. The issue meant that figures senior managers used to evidence compliance were inaccurate (too high) and that all staff did not receive the training the trust had decided staff of their level and grade required.

However:

- There was a clear statement of vision and values, driven by quality and safety.
- The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others
- The trust's staff in all areas knew and understood the vision, values and strategic goals.

Vision and strategy for this service

- The trust's vision is to be nationally recognised for their specialism in the care of older people and as an organisation that provides excellent cancer care.
- Staff we spoke with were aware of the vision and strategy.
- The trust's values were based on the 'Your Health. Our Priority' promise. They were around the behaviours staff and patients felt helped deliver safe, effective and compassionate care.
- These values were grouped into three subjects' quality and safety, communication and service.
- The trust's staff were aware of the trust values and these were displayed on notice boards.

Governance, risk management and quality measurement

- The medical services were part of the medical business unit, which included general medicine, endoscopy, cardiology, geriatric medicine, endocrinology, gastroenterology, rehabilitation, respiratory and stroke medicine.
- There was a governance structure in place, which ensured some risks to the service were captured and discussed. However, during our inspection the trust's governance processes had not identified some key risks including: mandatory training allocation of competencies, completion of capacity assessments and the quality of DNACPR form completion.
- Incident reporting categorisation was not consistent across the medicine division, as outlined above (see safe). This meant that the board could not be assured that similar incidents were consistently reviewed or reported externally.
- Senior nursing staff expressed concern that there was a lack of understanding regarding the acuity and ward environments from nursing managers who made decisions on staffing. We established that the decisions were made based on individual clinical judgement and there was no guidance document or risk assessment undertaken regarding the decisions. Nurses told us and we saw evidence that they repeatedly reported their concerns regarding staffing. Staff told us that despite incident reporting concerned, nothing changed.
- The governance framework enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- In terms of clinical audits, a quarterly report was submitted to each business group with detail of their audits undertaken. A summary report was then submitted to the quality governance committee as part of the governance framework. This report advised the committee on the audits completed within a timeframe and whether assurance was given or not. If not what the risk factor is. If there was a risk the business group advised the committee of the risk or requested support/ action to be taken.
- Meeting minutes reviewed showed discussion of governance issues and shared action plans to secure service improvement.
- There were regular team meetings and huddles to discuss issues and management actions.
- Across the medical division we noted that from May 2016 to February 2017 the trust was consistently above the ceiling target for agency expenditure. In view of the expenditure for agency staffing (£1,138,444 for February 2017), the sustainable delivery of quality care was put at risk by the financial challenge.

Leadership of service

- Staff stated that the executive team and board members were accessible.
- Ward staff felt well supported by their line managers and the senior leadership team. However, senior nurses did not feel supported by nursing managers. Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared.
- All staff we spoke with were aware of the whistleblowing policy.
- Leaders were sighted on the challenges to good quality care and were able to identify actions needed to address them.

Culture within the service

- Staff told us that senior leaders got ideas from 'the ground up to make improvements', which helped them to feel valued.
- Operational staff told us that managerial changes had improved the culture.
- Staff felt encouraged to raise issues and concerns and felt confident to do so.
- We observed staff teams working collaboratively and sharing responsibility to deliver care.

Equalities and Diversity – including Workforce Race Equality Standard

- The trust had recently published and equality, diversity and inclusion report which was available on the website. This showed how the trust were meeting its obligations under the Equality Act (2010).
- The trust's workforce was fairly representative of the growing ethnic diversity in the local community, religious beliefs, sexual orientation and the population. However, in common with most health organisations, women make up the majority of their workforce.
- The trust was in the lowest 20% of trusts across the country when staff were asked if they had experienced discrimination at work but there were some patterns of difference across equality groups. During our inspection we asked staff about this and no one we spoke with felt that they had been discriminated against. The trust had a Workforce Race Equality action plan to address this.

Public engagement

- Business and operational plans for Stockport NHS Foundation Trust were available online to the public via their website and gave information about performance and strategic plans for the Trust.
- The trust's website contains a wide range of information including policies and procedures, condition specific advice and information about the hospital.
- Information on how patients, carers and relatives could provide feedback to the trust were available on the website. This included a number of ways to give feedback including an automated web form.
- The trust used social media sites to engage with the public, such sites were maintained, up to date and utilised regularly.
- Stockport NHS Foundation Trust appointed three young members of the public to act as youth ambassadors to represent the views of younger people in decision making about the trust.
- The trust has around 17,500 public and staff members who provided input into trust decisions, take part in surveys, elect governors and receive a member's newsletter.

Staff engagement

- Staff told us that they received regular email communication from the trust providing updates on changes and improvements.
- There were regular staff engagement meetings and offers and opportunities to meet with the senior team.

Innovation, improvement and sustainability

- Patient surveys recorded via IPads enabled the trust to view results daily by clinical area.
- The trust had introduced an improving wound care diploma devised and agreed by the newly formed Wound Care Steering Group, chaired by the district nursing service.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had introduced an improving wound care diploma devised and agreed by the newly formed Wound Care Steering Group, chaired by the district nursing service.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that records are securely stored.
- The trust must ensure there is an adequate skills mix on all medical wards and that staff have the right level of competence to effectively nurse the patients they are asked to care for.
- The trust must do all that is reasonably practicable to ensure there is safe staffing on the medical wards.
- The trust must ensure that patient risk assessments are completed and updated at regular intervals.
- The trust must ensure that it is compliant with the Mental Capacity Act and that all staff have the required level of training in this area.
- The trust must ensure that its mandatory training reporting systems are accurate and reflective of the training needs and requirements of all staff.
- The trust must ensure all staff are up to date with their mandatory training.
- The trust must ensure that at all times there is a suitably trained member of staff on each medical ward and unit that has current adult life support training.
- The trust must ensure there is consistent categorisation of the same type of incident in the trust's incident reporting system.
- The trust must ensure safeguarding training levels for staff are in accordance with the trust's own policy and best practice guidance.
- The trust must address the delayed transfers of care and formulate an action plan outlining how it will address this issue within a reasonable time period.
- The trust must ensure nursing intervention records are consistently completed.
- The trust must ensure that thickening powder is securely stored.
- The trust must ensure that patient's dignity is preserved at all times across the medicine division.

Action the hospital SHOULD take to improve

- The trust should ensure there are regular morbidity and mortality meetings across the medicine division.
- The trust should consider implementing clear guidance for senior staff to use when making judgments about staff moves.
- The trust should ensure that where audit findings fall below the trust's expected standards, action plans to address this are created and monitored.
- The trust should improve the appraisal rate for the medicine division.
- The trust should ensure the proportion of patients seen by a cancer nurse specialist is above audit minimum standard of 80% for lung cancer.
- The trust should ensure that patients' discharge summaries are published within 48 hours.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 1. Service users must be treated with dignity and respect. 2. Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— a. ensuring the privacy of the service user; b. supporting the autonomy, independence and involvement in the community of the service user; c. having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user. The trust was not always ensuring the privacy of the service users it was providing care for.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; g. the proper and safe management of medicines;

This section is primarily information for the provider

Requirement notices

h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

The trust was assessing and responding to risks to the safety of service users. The trust was not at all times managing medicines safely.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; d. maintain securely such other records as are necessary to be kept in relation to— i. persons employed in the carrying on of the regulated activity, and ii. management of the regulated activity; The trust was not monitoring and mitigating risks to service users effectively. Records were not always maintained and stored securely.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. There were not always sufficient numbers of suitably qualified persons deployed across the medical and urgent care area. This was observed to have a direct negative impact on patient care and experience.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...