Care Quality Commission

Stockport NHS Foundation Trust

Stepping Hill Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

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. 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.

We carried out an announced inspection of Stepping Hill Hospital on 19–22 January 2016 as part of our comprehensive inspection of Stockport NHS Foundation Trust.

Overall, we rated Stepping Hill Hospital as 'Requires Improvement'. We found that services were provided by dedicated, caring staff, and patients were treated with dignity and respect. However, improvements were needed to ensure that all services were safe, effective, well led and responsive to people's needs.

Our key findings were as follows:

Cleanliness and infection control

- The hospital had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Overall, patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines however some areas in the maternity suite were dusty such as emergency equipment, feet of chairs and some work surfaces. Monthly audits took place and those for September and October showed areas had been identified where furniture and fittings were marked and dust had accumulated. Actions taken included requests for new furniture, changes to cleaning regimes and additional cleaning records. Some of these measures had been put into place.
- In the medical division hand hygiene audits were completed monthly and results showed varying compliance with an average compliance of 92.3% in July to 71.8% in October.2015 showing inconsistency and an overall downward trend
- Also in the accident and emergency department we reviewed hand hygiene audit results for an eleven month period. This showed that for seven out of eleven months the department scored less than 90% in these audits that was less the Trust target.

Medicines management

- In the Urgent and Emergency care department medications were not always securely stored and some patients experienced delays in receiving pain relief.
- In the Critical Care unit there was a practice of pre-filling syringes with intravenous medicines and then storing them in the fridge which was left unlocked. This was not safe practice. We raised this with the trust at the time of our inspection and the practice was immediatley ceased.
- In the paediatric unit during our unannounced inspection, staff medications were found to be stored within a cupboard with patient medication. On examination of the cupboard, codeine phosphate belonging to the trust was found in with staff's own medications. This gave cause for concern that trust medications may be being taken for staff members' personal use. Additionally this medication should have been securely stored.

Summary of findings

- The high-dependency unit fridge was running with a high temperature (15 degrees C) and had not been checked that day. This meant medications may not have been stored appropriately and as a result efficacy could be affected.

Nurse staffing

- The hospital used a nationally recognised acuity tool to determine the number and skill staff required this was reviewed twice yearly.
- Care and treatment were delivered by committed and caring staff who worked well together to provide patients with good services.
- In the Urgent and Emergency care department the staffing levels required improvement. The expected day time shift for the department were 12 registered nurses and three health care assistants. These levels of staffing were not always met. In a four month period we found that 54 out of 121 shifts were short staffed by at least one registered nurse. In the same period we found that 42 of 121 shifts were short staffed by at least one health care assistant.
- On two of the five days we visited the department the staffing establishment was lower than planned. On one day there was one less nurse and one less health care support worker than planned and on another day there was one less nurse.
- Registered nurses were moved to other clinical areas on occasion, leaving the department short staffed. An incident reported by the department in October 2015 outlined that staff had been moved from the emergency department on three dates. This incident outlined that patients experienced delays in receiving treatment on one of these days due to staffing levels in the emergency department.
- The matron told us that the expected ratio for staff to patients was one nurse to four patients in the major's area and one nurse to two patients in the resuscitation area. We observed times when these ratios were not met. The nurse who was responsible for the patients placed in the corridor was observed caring for between eight and ten patients in the corridor. These patients were all awaiting trolley spaces in the majors or resuscitation area. This meant that there was double the number of patients to one nurse than expected at times.
- There were a number of trained nurse vacancies across the medical service , these varied across wards with some wards being fully staffed , however some areas had significant vacancies, for example vacancy rates were 64% on the frail elderly unit.
- Shortfalls were covered by bank and agency staff, however, this is not a sustainable position and nurse vacancy rates within the service were of concern.
- Similarly staff turnover rates varied with the highest being 67% on the escalation ward.
- Nurse staffing numbers within the paediatric services required improvement. Nurse staffing levels on the Treetops ward did not reflect Royal College of Nursing (RCN) standards and on the neonatal unit did not always meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). The trust did not have a senior nurse, above band five, on 37 of 93 shifts from 14 December 2015 to 13 January 2016. Over the same timeframe the trust did not ensure there was a nursing staff member who was Advanced Paediatric Life Skills (APLS) trained on 12 of 93 shifts. From 14 December 2015 to 13 January 2016 the trust did not ensure there was a nursing staff member with HDU training on 14 of 93 shifts. On three of the shifts there was no staff member that was APLS or HDU trained.
- For each shift on the paediatric ward one nurse was identified to go into the HDU should patients' needs require HDU care. This member of staff was not always HDU trained.
- BAPM guidance recommends there is a supernumerary co-ordinator on each shift in the neonatal unit. There was no supernumerary shift co-ordintaor on any shifts.
- Midwifery staffing was described as a day to day "challenge" by the managers. 96 incidents had been reported between November 2014 and October 2015 about low staffing numbers which had affected patient care.
- In October 2015 19 midwifery day shifts and 12 night shifts were not filled with bank or agency staff. These shifts were then working with below the identified number of staff needed.

Summary of findings

- Birth rate plus acuity tool was used to assess the necessary staffing numbers for the maternity service. To assess the acuity on an ongoing basis the clinical lead midwife or the bleep holder for the service checked the roster for the service at 8am including any sickness then did a walk around the unit including the gynaecology ward, to ensure there were sufficient staff with the necessary skills and experience to meet the needs of the patients.
- The ratio of midwives to births was 1 to 30 which was worse than the England average of 1 to 27.
- Actions to improve the midwifery staffing included an additional five full time midwives on 12 month contracts to fill the maternity leave and long term sickness vacancies.
- There was an escalation policy which included moving staff between areas, using non clinical staff to provide cover in a clinical area or asking midwives to come in from home.
- In order to support the staff on the maternity units the band 7 midwives had an on call rota and there was always a supervisor of midwives on call.
- There was a supernumerary co-ordinator on the delivery suite every day. This met with safe staffing guidance.

Access and Flow

- In December and January 2015 the hospital performed worse that the England average with 20% and 30% of patients respectively waiting between four and twelve hours to be admitted.
- Data showed that the percentage of patients leaving Emergency and urgent care before being seen was consistently worse than the England average, apart from September 2014 where the hospital performed about the same as the England average and May 2015 where they performed better than the England average.
- From July 2013 to July 2015, the total time patients spent in the emergency department (average per patient) was consistently higher than the England average. This means that on average patients spent more time in the emergency department at Stepping Hill Hospital that at other hospitals of a similar size across England.
- There were 199 black breaches from November 2014 to October 2015. 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.
- We observed the department lacked capacity to accommodate patients on all five days of our visit.
- We observed patients being accommodated in the main corridor of the department during all five days of our visit. The time these patients were resident in the corridor ranged from ten minutes to just over two hours.
- As a result of bed pressures medical patients were often placed on surgical wards In August 2015 there were 193 medical patients placed on surgical wards and 142 in September 2015.This meant that this group of patients were not always placed in areas best suited to their needs.
- In addition patients experienced a number of moves during their stay. There were also examples of patients being moved across wards out of hours and some patients experienced one or more moves during their stay in hospital. Between October 14 to September 15 257 patients moved more than 4 times and 632 moved more than 3 times

This is not considered a positive experience for patients.

Leadership and Management

- The senior team in the majority of core services were visible and accessible and well known to the staff.
- However not all staff in the Urgent and Emergency care department could articulate the current strategy and vision for the service, however staff told us that they felt supported by their senior leaders.
- Governance systems in the Maternity and Gynaecology had not identified several clinical issues we found. There was a lack of monitoring of performance against trust or national targets and therefore a lack of understanding of where improvements were necessary. Also there was no date of entry or review for risks on the divisional risk register for Maternity and Gynaecology services. Not all risks that had been identified were recorded.
- Risks in the Urgent and Emergency care department were not always appropriately identified and monitored. Risks on the risk register were past their date for review and actions taken in response to these risks were not always evident.

Summary of findings

We saw several areas of outstanding practice including:

- The introduction of PCR testing for clostridium-difficile ensured rapid results were available to medical teams to reduce the potential spread of infection within inpatient areas.
- The paediatric unit had created specific packs to support parents whose children were having specific procedures for example a DVD and self-help pack had been created for children having spiker surgery. This included contact details for parents who had had a similar experience.
- The neonatal unit had a range of leaflets that complemented their 'baby passport'. The leaflets were staged depending on the baby's development. Parents were prompted via the 'baby passport' and nursing staff to know which information leaflets were relevant to them at a particular point in time.
- Care on the Laurel suite and on the Bobby Moore Unit was outstanding. Staff were strongly person centred and understood and respected the totality of patient's needs. They involved patients as partners in their care and provided high levels of emotional support.

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

Importantly, the Hospital must:

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 patient manual handling.
- 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 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 the trusts internal escalation policies are followed appropriately.
- Ensure that there is an adequate policy or procedure to guide the practice of 'boarding' to ensure patient safety.
- Ensure that all risks identified in relation to the emergency department are appropriately risk assessed and appropriate control measures are in place.

Medical Services

- Ensure the agreed establishment of qualified nurses are employed an deployed in the medical division
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- Ensure patients are not transferred from ward to ward for none clinical reasons and out of hours

Critical Care

- Ensure that the practice of pre-filling syringes with intravenous medicines and then storing them in the fridge is not continued. For any scenario where a clinical decision results in this practice being reconsidered, then a detailed risk assessment should be undertaken, which should include the involvement of the critical care pharmacist.

Maternity and Gynaecology

- Ensure all staff are up to date with adult basic life support training
- Ensure there is a system in place to learn and share learning from incidents.
- Ensure all steps of the safer surgery checklist are completed for all surgical procedures in the obstetric theatre.
- Ensure a system is in place to monitor patient outcomes against set local or national targets.
- Ensure midwives are up to date with skills and drills training
- Ensure midwives assisting the anaesthetist in the obstetric theatre are trained in line with national guidance.
- Ensure there is a system for continuous monitoring the quality of the service provided and make necessary improvements.

Children and Young People

- Ensure there is a senior staff member on each shift on the paediatric unit.
- Ensure there is a staff member that is HDU trained on each shift on the paediatric unit.
- Ensure the door exit systems on the paediatric and neonatal unit are secure.
- Ensure staff members' medications are securely stored and do not include the trust's generic medications.
- Ensure that fridge temperatures are regularly checked, documented and acted upon in accordance with the trust's policy and procedures.
- Ensure all staff working with children and young people have level three safeguarding training.

In addition the hospital should:

Urgent and emergency care

- Ensure that there is an adequate provision of equipment used for resuscitation in all areas of the emergency department.
- Ensure patients are offered food and drinks where clinically advised by staff members
- Ensure that staff within the emergency department receive their annual appraisals
- Ensure that the care provided to patients presenting with sepsis is evidence based and in line with national and local guidance and ensure that this is reviewed and audited regularly.

Medical Services (Including Older People services)

- Ensure that records trollies are kept locked when unattended to ensure they are not accessible to the general public.
- Ensure hand hygiene rules are met by staff
- Ensure patients receive care on a designated medical ward wherever possible

Surgery

- Ensure the standardisation of defibrillators across the trust to comply with Resuscitation UK guidelines.
- Enusre the procedures for checking of resuscitation equipment and whether this is now a daily or monthly check to ensure consistency between wards.
- Ensure that all resuscitation trolleys are sealed at all times when not in use. They should also ensure that when they are checked and re-sealed the relevant unique reference number recorded for safety and audit purposes.
- Ensure that there is compliance in with the medicines administration policy concerning the recording of wastage of controlled drugs that have not been used.
- Ensure the policy regarding storage of IV medicines which are not in a recognised medicines cabinet, to ensure this complies with RPSGB guidance.

Summary of findings

- Ensure their policy and procedures concerning PGD and ensure staff awareness in light of new electronic prescribing practice.
- Ensure that patient records are stored securely and cannot be accesses by non-designated persons.
- Ensure steps to improve compliance with mandatory training and improve recording and accuracy of compliance are taken.
- Ensure compliance with staff annual appraisal targets are achieved .

Critical Care

- ensure that all staff receive training on the principles of Duty of Candour.
- ensure that work continues to improve the access and flow in the department and improvements are made to the issue of delayed discharges.
- ensure that nutritional supplements are not stored in the visitors kitchen
- consider how it is going to meet the requirements of the latest health building notes guidance in any future expansion of the critical care service.

Maternity and Gynaecology

- Ensure that improvement in the assurance that all emergency equipment is in full working order at all times.
- Ensure input from the pharmacy department for the management of medicines on the maternity services.
- Ensure there is a system in place to monitor improvements identified during through audits.
- Ensure sufficient specialist midwifery cover to support patients with additional mental and physical health needs is provided.
- Ensure I times against the national 2 week cancer referral to treatment targets areimproved .

Children and Young People

- Ensure there is supernumerary co-ordinator on the neonatal unit in accordance with BAPM guidance.
- Ensure there is a staff member with APLS training on each shift on the paediatric unit.

End of life care

- Ensure that when audit results are sent to the business groups for actions these are consistently followed up. Issues with the completion of DNACPR forms had been highlighted in audits yet the completion of these continued to be variable in in quality.
- Ensure that the actions in the audit that identified a risk in terms of lapsed syringe driver training is followed up and ensure all syringe driver training is up to date.
- Ensure all risks affecting the provision of EOLC are identified on one risk register. Some risks identified by the service, for example the level of EOLC consultant cover, were not included on the risk register. This meant that potential risks may not be managed as effectively as they would if they were regularly reviewed.

Outpatients and diagnostic Screening

- Ensure that number of overdue outpatient follow-up appointments, particularly in gastroenterology, are reduced.
- Ensure that floor areas in outpatients B can be cleaned in line with HBN00-09 guidance for Infection Control in the Built Environment.
- Ensure the staff groups requiring level three children's safeguarding training in the Safeguarding Children Training and Competency Strategy is reviewed.
- Ensure theprovision of sufficient car parking for patients at the Stepping Hill site is considered.
- Ensure patient feedback about changes made to outpatient services as a result of complaints is considered.
- Ensure participation in the Imaging Services Accreditation Scheme (ISAS) and the Improving Quality in Physiological Services (IQIPS) accreditation scheme

Summary of findings

Professor Sir Mike Richards
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	Requires improvement 	We found that patients in the emergency department were not always protected from the risk of avoidable harm. Staff did not always observe appropriate measures to protect patients from avoidable infections. Medications were not always securely stored. The double checking of medications was not always undertaken in line with national guidance and trust policy. Patient's records were not always completed fully and contemporaneously completed Patient risk was not always assessed appropriately. Nurse staffing levels were not always appropriate to meet the needs of patients. Compliance with mandatory training varied with some subjects including basic life support having an uptake below the hospitals target. 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 (CEM). The service participated in local and national clinical audits we found that performance in these audits varied. Action plans were formulated to address identified shortfalls however the monitoring of actions was variable, with some actions not updated for over six months. Patients' nutritional and hydration needs were not always identified and were not always addressed appropriately. Some patients did not receive timely analgesia. Data from national surveys showed that patients treated within the trusts had outcomes which were similar to patients treated in other trusts in England. The appraisal rate for nursing staff in the department was very low at 37.7%. Staff sought appropriate consent from patients before delivering treatment and care. 90% of patients would recommend the Emergency Department at Stepping Hill Hospital to their friends and family. Some patients spoke positively

Summary of findings

about the way staff treated them however; some patients raised concerns with us about their treatment and raised issues regarding the lack of privacy and dignity in the department.
We observed that patients comfort was not always maintained and we observed patients in visible distress.
We found that the trust had made some efforts to understand the needs of the local population and adapt services to meet their needs.
There was a separate paediatric department which was well equipped to deal with paediatric patients.
The department had implemented a community assertive in reach team (CAIR) who worked to facilitate the discharge of elderly patients from the department by implementing additional support and care at home.
Within the department there was a designated three bedded hyper acute stroke unit and there was a full time alcohol liaison nurse based in the department.
We found that 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. Ambulance crews frequently queued in the department corridors with patients waiting to be admitted and handovers were delayed sometimes by over 50 minutes.
The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The hospital consistently failed to meet this target.
Patients were routinely accommodated in the main 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 no means for patients to call for help and assistance if they were left unattended.
We found that staff did not always follow the guidance and actions outlined in the trusts escalation policy which led to delays in the department.
Not all staff could articulate the current strategy and vision for the service.

Summary of findings

Monthly governance meetings were held and were attended by senior staff.
Risks were not always appropriately identified, monitored and there was not always evidence of action taken where appropriate.
Staff spoke positively about local leaders and told us they were visible and staff felt able to able approach them. Staff told us the culture within the service was open. Staff did not always feel supported by senior clinicians external to the department and felt they were not always visible at times of peak demand. Staff told us that the chief executive and other executives were a visible presence in the department on a regular basis.
Managers made efforts to engage the public when planning services and had an active service user group

Medical care (including older people's care) — **Requires improvement**

Medical services at Stepping Hill Hospital were rated as Requires Improvement overall .
There were nurse and medical staff vacancies within the services . Gaps in shifts and rotas were filled by agency and bank nurses. Gaps in the medical rotas were filled by locum doctors.
Although the wards were adequately staffed at the time of our inspection, the reliance on bank and agency staff on some wards and departments meant that this was not a sustainable position.
Recruitment into wards and medical specialties with high vacancy rates required prompt action to address the shortfalls.
Mandatory training was provided annually, face to face and via e-learning. However the completion rates for both medical and nursing staff were below the expected target.
Incidents were reported and lessons learnt shared amongst staff. Staff knew how to access the incident reporting system and could tell us about incidents they had reported. Risk assessments were completed and staff implemented measures to reduce risks.
Hand hygiene audits were completed monthly and results showed varying compliance with an average compliance of 92.3% in July to 71.8% in October.2015 showing inconsistency and an overall downward trend

Summary of findings

The environment was clean and tidy and staff had access to the equipment they required.. Medicines were managed safely and stored securely within the medical division.
Services worked in coordination with partners and patients were appropriately referred to specialist services. Staff treated patients with respect and dignity, offered support and included them in care planning. Patients received a caring service and staff discussed treatment plans with patients to ensure a person-centred approach.
As a result of bed pressures medical patients were often placed on surgical wards.
In August 2015 there were 193 medical patients placed on surgical wards and 193 in September 2015.This meant that this group of patients were not always placed in areas best suited to their needs. In addition patients experienced a number of moves during their stay. Significant numbers of patients experienced 3 or 4 moves. This is not a positive experience for patients.
In addition, although there was a focus on discharge planning there were a number of patients who were experiencing delayed discharge and remained in hospital longer than they needed to be. This again is not a positive experience for patients.
More positively, services were planned to meet the needs of the local population and included national initiatives and priorities.
The trust 18 week referral to treatment times were better than the England average between September 2014 and August 2015, except for a decrease in January 2015.
Risk registers were in place and discussed at team meetings. Staff were aware of the trust's values and vison. Staff felt well-supported by managers and colleagues.

Surgery

Good

Surgery services at Stepping Hill Hospital were rated as good overall because during our visit we found services generally to be safe, effective, caring, responsive and well-led. Those patients who we spoke with who used the service felt satisfied with their care and treatment and they reported a positive experience.
Services were deemed safe as there was a good culture of reporting incidents and safety issues.

Summary of findings

Investigations into incidents were thorough and there was evidence of learning and implementation of measures to improve quality and safety. There were sufficient staff to maintain patient care and safety and staff had received the appropriate training to enable them to keep people safe. We found surgery services to be compliant with the World Health Organisation (WHO) checklist and National Patient Safety Agency (NPSA) 'five step to safer surgery' operating procedures. The identification of patient risk and the provision of care for the deteriorating patient were found to be good. The environment was clean and hygienic with low levels of healthcare associated infections.

Care was effective as it was planned and delivered in line with evidence based guidance and best practice. Patient outcomes were satisfactory with performance similar to other trusts and England averages. Multidisciplinary team working was good with satisfactory access to a range of specialities. Staff were experienced, competent and enthusiastic; they were knowledgeable and were supported to improve their capability. There was effective assessment of mental capacity and consent to treatment and where applicable deprivation of liberty safeguards were applied appropriately.

Staff showed kindness and compassion to their patients and protected their privacy and dignity when providing care and treatment. Patients told us staff were caring and respectful and that they were kept informed and involved in the they treatment received. This was reflected in good friends and family test results, which were better than the England average.

Surgical services were responsive. The hospital met the national target time of 18 weeks between referral and treatment targets overall, though they did fail to meet these for some individual specialities. There was evidence to show attention to individual patient needs and support for those with complex needs. Complaints were handled and responded to appropriately and the feedback was used to improve services for patients. Theatre utilisation was efficient which enabled better use of

Summary of findings

resources and there were no issues identified with access to treatment and flow through the service. Discharges were considered to be well organised and appropriate.
Surgical services were well-led both on a ward level and at clinical service level. Managers were enthusiastic and passionate about their service and there appeared to be a positive supportive culture throughout the surgical care group. Staff felt there was good team working and support at all levels.

Critical care

Good

We have judged that overall, the critical care services provided at Stepping Hill Hospital were good.
There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. We found a culture where incident reporting and learning was embedded and used by staff.
There was strong clinical and managerial leadership at unit and business group level. The unit had a vision and strategy for the coming years developed in accordance with the 'Healthier Together' proposals for Greater Manchester.
There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

Maternity and gynaecology

Requires improvement

Maternity and Gynaecology services at Stepping Hill Hospital were rated as requires improvement overall There was a lack of learning and feedback from incidents to ensure necessary changes were made to prevent recurrence. Not all medicine administration practices met with best practice guidance and some steps in the safer surgery checklist were not completed during surgical procedures. Half of the staff in maternity and gynaecology were not up to date with adult basic life support training and the systems for checking emergency equipment such as those used for resuscitation did not provide assurance that it would be in full working order. There were around one quarter of midwives who were not up to date

with their maternity specific training and annual appraisals and their competence to carry out some practices had not been assessed. Midwifery staff shortages meant some shifts had staff numbers below those set by the trust. Some actions had been taken to improve this. Medical staffing was sufficient on the wards; however there was a shortage of consultant cover in the ante-natal clinics.
Audits took place to monitor the quality of the service provided; however there was a lack of clarity about how any areas for improvement identified were monitored. There was no system for monitoring patient outcomes in maternity services to assess the quality of service delivered. Areas of potential concern we found had not been identified by the trust. Information gathered was not used to benchmark performance against other trusts or national targets There was no date of entry or review for risks on the divisional risk register. Not all risks that had been identified were recorded

Services for children and young people

Good

We judged that though providing a good service overall services for Children and Young people at Stepping Hill hospital were outstanding in terms of being caring.
The service provided an integrated approach to acute and community services, both services operating from the Tree house unit. This approach ensured that children were seen by the same group of staff in hospital and the community. Family centred care was the prevailing philosophy in children and young people's services. Children were involved with and positioned at the centre of their care.
We found a positive culture where incident reporting and learning was embedded and used by staff. There was strong clinical and managerial leadership within the units and at business group level.
There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting

Summary of findings

and escalation to the trust board. Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

Though overall we rated the service as good there were some issues especially in the safe domain that required improvement. Nurse staffing on the paediatric unit is not in line with the RCN guidance on safe staffing (2013). The trust did not have a band six staff member on 37 of 93 shifts from 14 December 2015 to 13 January 2016. In a further six shifts the trust did not a band six staff member on for half of the shifts. From 14 December 2015 to 13 January 2016 the trust did not ensure there was a nursing staff member with APLS on 12 of 93 shifts. From 14 December 2015 to 13 January 2016 the trust did not ensure there was a nursing staff member with HDU training on 14 of 93 shifts. Whilst there have not been any patient safety incidents as a result of this, it is recommended by the Royal College of Nursing that the trust should have at least one APLS trained staff member on each nursing shift along with a staff member who is band six or above.

The security system that was in place on the neonatal unit and paediatric unit used an intercom system for visitors entering the ward and a swipe card system for staff. However, for exiting the ward, there was a push button allowing visitors to leave without being supervised. This meant there was a risk that children could leave the paediatric ward unsupervised and also raised a concern in relation to child abduction.

As part of our unannounced inspection on the paediatric assessment unit, staff medications were stored within a cupboard with patient medication. On examination of the cupboard, codeine phosphate belonging to the trust was found in with staff's own medications. This gave us concern that trust medications may be being taken for staff members' personal use. Additionally this medication should have been securely stored. We told the sister on the ward about this at the time of inspection.

Drugs requiring storage below certain temperatures were stored in fridges and most checks were in place to monitor fridge temperatures. On the

paediatric unit, not all entries were complete on one of the fridges. This issue was discussed with the ward manager who escalated this to the safety huddle meeting. On our unannounced inspection, the high-dependency unit fridge was running with a high temperature (15 degrees C) and had not been checked that day. This meant medications may not have been as effective. We told the ward staff about this.

End of life care

Good

End of Life services at Stepping Hill Hospital were rated as good overall because during our visit we found services generally to be safe, effective, caring, responsive and well-led.

Incident reporting systems were in place and actions were followed up at ward level via handover and within the divisions at business group meetings. There was good knowledge of anticipatory EOL care medication within the SPC team which was clinically led by a consultant in palliative medicine. Mandatory training for EOL was excellent and staff knew how to access the SPC team and the safeguarding team when needed.

There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) document which facilitated support for the dying person in the last days and hours of life. There was an audit programme in place for EOLC and the service had taken action to address targets not met in the 2014 National care of the dying audit for hospitals audit.

There was a microsite on the trust intranet where information about palliative and EOLC could be accessed. This included links to the hospice, leaflets, care plans, standard operating procedures and policies and staff said they used it regularly. We saw good evidence of multi-disciplinary and team working, including in the mortuary where staff were working well together in the absence of a manager.

There was one nurse from the SPC team on call at weekends but no EOLC medical cover. Access to information was good with a new system (EPAC) in place which allowed different EOLC care providers access to up to date information about their patients.

Summary of findings

EOL care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. The SPC team saw most patients within 24 hours of referral. Patients at the end of life were allocated a side room where possible. There was a rapid discharge process in place and this was being audited with actions identified and monitored to address areas where improvement was required. There was evidence that concerns and complaints were addressed at all levels, and that learning from surveys, audits, complaints and incidents was disseminated to staff.
Several of the systems and processes in place around EOL care were very new at the time of our inspection. The individual plan of care (IPOC) which had replaced the Liverpool Care Pathway (LCP) was new and had not yet been rolled out to all staff. Staff said that the safeguarding paperwork was new and they were still getting used to it. The EOL mandatory training was new and had not yet been delivered to all staff. The electronic care portal for anticipatory care (EPAC) was in its infancy. While all of these improvements to EOLC were positive and appropriate, they were not yet fully established which meant it was not possible to fully assess their impact on the patients and the service.
Similarly there were several further developments in the pipeline, including a new forum which would include discussion around EOLC governance including the use of a uDNACPR across all EOL services which was another new development being planned. A performance dashboard to provide an overview of how EOL services were performing against their agreed targets was in draft format. The SPC team was due to be fully integrated between the hospital and the community in March 2016 which will involve further changes. However, the EOLC leads we spoke with had a clear vision of the direction the service was moving in and were working towards it. They were conversant with the latest guidance and had registered for the Transform programme which was developed to provide hospitals with a comprehensive service improvement framework for EOLC.

Summary of findings

Outpatients and diagnostic imaging

Good

Outpatient and Diagnostic imagaing services at Stepping Hill Hospital were rated as good overall because during our visit we found services generally to be safe, effective, caring, responsive and well-led. Staff were encouraged to report incidents. Lessons were learnt from incidents and these were shared openly with different staff groups. Duty of candour was understood and applied when necessary. Outpatient and diagnostic imaging areas were clean and tidy. An 'I am clean' labelling system was in use. Regular audits were carried out to review infection prevention and control and handwashing. PCR testing had been introduced to speed up time from suspected clostridium difficile to test results. Equipment was checked and maintained correctly on most areas we visited Medicines were stored correctly and only designated staff had access to medicines. Stock was checked weekly and replenished by the pharmacy team. Fridge temperatures were recorded, although minimum and maximum temperatures were not logged. Prescription pads and medical gases were stored safely.

Records were a mixture of electronic and paper notes. Paper notes were stored securely. Staff logged off computer systems when not in use ensuring information security.

Responsibilities and procedures in relation to adult and children's safeguarding were understood by staff.

Nursing staffing was organised to provide appropriate skill mix and numbers of staff. Bank workers received inductions which were documented. Radiology medical cover was provided 24 hours a day, supported by outsourcing of reporting at evenings and weekends. Locum consultants were used to supplement the current establishment. There were five consultant vacancies at the time of our inspection and work was ongoing to fill these posts.

Business continuity plans were in place to support staff in times of equipment failure, staffing shortages or major incidents.

Evidence-based care and treatment was provided in line with national and local guidance. Services were audited locally and benchmarked against other local services. Staff were supported to maintain and

develop skills and knowledge. Extended roles were encouraged and valued for both qualified and unqualified staff groups. Appraisal rates were generally more than 90% with some services achieving 100%. Teams worked well together to deliver effective patient care. Diagnostic imaging was available seven days a week

Only two percent of patients were seen in outpatients without their full medical record. Diagnostic images were stored electronically and images from other hospital sites could be viewed via this system. Staff understood the principles of consent and obtained consent correctly when required. Mental Capacity Act training had been received by over 90% of staff in Diagnostic and Clinical Services.

Staff were kind, caring and compassionate in outpatients and diagnostic imaging. They were sensitive in their communications with patients and understood and respected individual needs. Privacy and dignity was maintained at all times in the clinical environment. Patients were involved in making decisions about their care and treatment. They were given information and time to ask questions. Ninety percent of patients would recommend outpatients to their friends and family. In the Laurel suite this rose to 100%. Care in the Laurel suite and Bobby Moore Unit was outstanding. Patients we spoke with were very complimentary about the care and support they received.

We rated outpatients and diagnostic imaging as good for the responsive domain. Services had been planned and developed to meet the needs of local people and access to care was managed to take account of people's needs including urgent needs. There were a number of rapid access and drop in clinics. The Bobby Moore Unit ran a one-stop breast clinic service. Waiting times for diagnostic imaging and urgent cancer services were consistently below (better than) the national average and there were rapid access and drop in sessions five days a week in radiologyThere was a transition clinic for young people with diabetes to support their move from childrens to adult services. In outpatients, patients were kept informed of any delays. They were able to leave the department and return later if delays were

significant. Start times of clinics were monitored and incident reports were submitted if delays were long. There was flexibility within the appointment booking service to change appointments to more suitable times when needed. In pathology, electronic reporting of results was available within 45 minutes within the trust and within half a day for primary care testing. Specialist advice was provided from pathology to other teams within one working day of the request.

Individual needs were understood and considered when delivering services including dementia, learning disabilities, bariatric patients and the needs of children. Adjustments were made to enable these patients to access services.Staff received training in dementia awareness and there were three dementia champions in outpatients. Translation services were available face to face or via telephone, including the facility to translate written information leaflets. Staff from the mammography team had carried out work to increase the uptake of mammography for patients with a learning disability or mobility difficulties. Waiting areas in children's outpatients offered outstanding play facilities and equipment.

Information about how to complain was available in the areas we inspected. Staff were able to give examples of complaints and how lessons had been learnt and changes made to working practices. There had been a high number of complaints about outpatients A and B and changes had been made in response to this.

There were four specialities within the trust with high numbers of patients overdue a follow up outpatient appointment. These were ophthalmology, gastroenterology, respiratory medicine and cardiology. There were plans to reduce the wait times for these patients but three of the specialities were behind the target set by the trust. In October 2015, 16.52% of patients waited for over 30 minutes before they saw a clinician. This rose to over 20% for some specialities.

Staff were aware of the vision and strategy for the service. They understood and demonstrated the trust's values. Objectives were set in line with the trust's strategic aims and outcomes. Monthly and quarterly performance meetings were held.

Summary of findings

Radiology reviewed 10% of outsourced reporting to monitor quality. Audits were completed regularly in diagnostic imaging. The risk register was up to date and actions were taken to mitigate risks and reviewed regularly.
Leaders ensured staff were informed and up to date through regular staff meetings. Staff at all levels told us that leaders were approachable and listened to suggestions or concerns. The culture was open and honest. Staff felt proud to work within outpatients and diagnostic imaging.
Diagnostic imaging and outpatient therapies used patient satisfaction surveys and used information from these to improve services. Outpatients had not completed a survey recently. There was evidence of planning to ensure sustainability of services including applications for investment in equipment. The diagnostic imaging service was taking positive steps to recruit radiologists and radiographers. The introduction of electronic clinic room booking had improved clinic utilisation in outpatients.

Stepping Hill Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Stepping Hill Hospital

Stepping Hill Hospital in a hospital in Stockport, Manchester. Stepping Hill Hospital is Stockport NHS Foundation Trust's main hospital, which looks after a population of approximately 350,000 people. There are approximately 833 inpatient beds on the site

The hospital hosts an Accident and Emergency department. Medical care services at the hospital 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 surgical services at Stockport NHS foundation trust are undertaken on the Stepping Hill hospital site. The surgical services carry out a range of surgical procedures such as trauma and orthopaedics, urology, ear, nose and throat and general surgery (such as gastro-intestinal surgery). The critical care services at the Stepping Hill Hospital provides care for up to seven level three (intensive care) patients and eight level two (high dependency) patients. Maternity and gynaecology services provided at Stepping Hill Hospital included offering pregnant women and their families antenatal, delivery and postnatal care. The department delivered approximately 3,000 babies every year. A range of gynaecology services and termination of pregnancies was also provided. The paediatric services are provided at Stepping Hill Hospital include a 17-cot neonatal unit. The neonatal units provide special care and high dependency care and a restricted number of intensive care cots (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit. Most other services for children and young people are provided in the Tree house unit. The ground floor of this unit is for children's outpatients clinics The first floor of the unit is split into three inpatient areas The specialist palliative care (SPC) multi-disciplinary team is based at the Stepping Hill Hospital Patients with end of life care (EOLC) needs are cared for on the general wards at Stepping Hill Hospital. Palliative care is also provided on Bluebell Ward which is situated near the hospital at The Meadows and provides care and treatment to patients needing NHS continuing healthcare (CHC).

Outpatient services provided from Stepping Hill Hospital are mainly held in two main departments There are a number of smaller clinics, some of which provide more specialised care. These include the Laurel suite, Bobby Moore Unit, Lilac suite, Chest clinic and outpatient therapies. The main children's outpatients are provided in a separate department in the Tree Tops Unit. Diagnostic imaging services are provided at Stepping Hill Hospital. MR scanning is carried out by an independent provider although this is based on the Stepping Hill site.

We inspected the hospital as part of the comprehensive inspection of Stockport NHS Foundation Trust

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Dr Gill Gaskin Medical Director for 6 years

Head of Hospital Inspections: Ann Ford , Care Quality Commission

The team included a CQC Inspection Manager, 16 CQC inspectors and a variety of specialists including a, Community Matron, Consultant Physician, Clinical Nurse Specialist:, Consultant Surgeon, Matron for Theatres, Midwife, Consultant Obstetrician, Paediatric Nurse Consultant, a Head of Safeguarding, a Senior Governance and Risk Manager, Clinical Governance lead, a Medical Director an Emergency Department nurse specialist, a Paramedic team manager, a Critical Care nurse, an End of Life Care Consultant and Nurse Specialist and an Expert by Experience

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

:

• Urgent and Emergency Department

Medical care including care for Older people

Surgical care

• Critical Care

Maternity and Gynaecology

• Children and Young People

• End of Life

• Outpatients and Diagnostic Imaging Services

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from the ward areas and outpatient services 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 received feedback through focus groups. We held a listening event on the 12 January 2016 where members of the public were invited to discuss their experience of services at Stepping Hill Hospital 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

Between January 2015 and October 2015 there were 71,594 accident and emergency attendances at Stepping Hill Hospital. Around 7 % of attendances were from children aged 0-16 years old, and there were 4,806 Accident and Emergency attendances from this age-group between July 2014 and June 2015.

There are a total of 833 beds at the hospital and serves a population of 350,000 people. Between June 2014 to July 2015, there were 35,825 surgical spells trust wide serving a population of around 350,000 people 27% of surgical stays were emergencies, 58% were day cases and 17% were elective.

There were 759 admissions to critical care and 692 discharges between April 2014 and March 2015 There were 67 deaths in critical care during this period.

Detailed findings

Hospital episode statistics data (HES) showed there were 4806 children and young people spells between July 2014 and June 2015.

Between April 2014 and March 2015 there were 1521 deaths at Stepping Hill Hospital. These figures include all deaths for patients over the age of 7 years.

Between April 2014 and March 2015 there were 581 acute referrals made to the specialist palliative care team.

Outpatient services employ over 40 whole time equivalent nursing and clerical staff and see approximately 368,420 patients per year trust wide (July 2014 – July 2015 attendances). Approximately 260,521 patients attended the outpatients at Stepping Hill Hospital between July 2014 and June 2015, 28% of which were new patients and 63% were follow up appointments. The remaining 9% of appointments made were either patient cancelled (1%) or the patient failed to attend (8%).

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Urgent and emergency services

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

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 91,579 patients between April 2014 and April 2015. Approximately 32.1% 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, 15 major's trollies, a three cubicle hyper acute stroke area, one sub-wait area and four examination rooms.

There is a self-contained children's department (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 during our announced inspection between 19 and 22 January 2016. We also carried out an unannounced visit to the department on 1st February 2016 as part of this comprehensive inspection. We spoke with patients and relatives, observed care and treatment and reviewed 16 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.

We received comments from our listening events and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

We found that patients in the emergency department were put at risk of avoidable harm and at times this risk was high. We found that safety was not a sufficient priority. The department were not recording and monitoring all data required for the safety thermometer initiative. Compliance with mandatory training varied with some subjects including basic life support having an uptake of below 90%. Staff did not always observe appropriate measures to protect patients from avoidable infections. Medications were not always securely stored. Some patients experienced delays in receiving important medications. The double checking of medications was not always undertaken in line with national guidance and trust policy. Patient's records were not always completed fully and contemporaneously. Patient risk was not always assessed appropriately. Nurse staffing levels were not always adequate to ensure safe patient care. Patients routinely experienced delays in receiving care and treatment.

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 (CEM). The service participated in local and national clinical audits performance in these audits varied. Action plans were formulated following these audits and the monitoring of actions was variable, with some actions not updated for over six months.

Patients' nutritional and hydration needs were not always identified and were not always addressed appropriately. Some patients did not receive timely analgesia. Data from national surveys showed that patients treated within the trusts had outcomes which were similar to patients treated in other trusts in England.

The appraisal rate for nursing staff in the department was on an upward trajectory from 60% in May 2015 to 80.2% in January 2016. Staff sought appropriate consent from patients before delivering treatment and care.

90% of patients would recommend the Emergency Department at Stepping Hill Hospital to their friends and family. Patient's privacy and dignity was not always maintained. Some patients spoke positively about the way staff treated them however; some patients raised concerns with us about how they were treated. Patients comfort was not always maintained and we observed patients in visible distress. The viewing room for deceased patients was not fit for purpose.

We found that the trust had made some efforts to understand the needs of the local population and adapt services to meet their needs. There was a separate paediatric department which was well equipped to deal with paediatric patients. The department had implemented a community assertive in reach team (CAIR) who worked to facilitate the discharge of elderly patients from the department by implementing additional support and care at home. The department also had a designated hyper acute stroke unit which was used to treat patient presenting with symptoms of stroke. This unit was observed working very effectively with competent staff providing excellent care to this group of patients.

We found that 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. Ambulances were frequently queued in the department corridors and handovers were delayed, on occasions by over 50 minutes.

The trust consistently failed to meet the four hour arrival to face to face consultation target. Patients were routinely 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 no means for patients to call for help and assistance.

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 not always follow the guidance and actions outlined in this policy which led to delays in space becoming available in the department.

We found that the department was not well led at a local level. The leadership did not ensure the delivery of

Urgent and emergency services

high quality person centred care. Not all staff could articulate the current strategy and vision for the service. Monthly governance meetings were held and were attended by senior staff. Risks were not always appropriately identified, monitored and there was not always evidence of action taken where appropriate.

Staff spoke positively about leaders and told us they were visible and staff felt able to able approach them. Staff told us the culture within the service was open. Staff did not always feel supported by senior managers external to the department and felt they were not always visible at times of peak demand. Staff told us that the chief executive and other executives were a visible presence in the department on a regular basis.

Managers made efforts to engage the public when planning services and had an active service user group.

Are urgent and emergency services safe?

Inadequate

We found that patients in the emergency department were put at risk of avoidable harm and at times this risk was high. We found that safety was not a sufficient priority particularly in relation to the way in which medicines were managed and the assessment and response to patient risk. Staff were aware of how to report incidents and had access to a trust wide electronic reporting system. There were seven serious incidents reported between November 2014 and October 2015. We found that investigations into serious incidents were comprehensive but actions and lessons learned were not always completed and reviewed.

Compliance with mandatory training varied within the emergency department. In some areas including basic life support the uptake of training was below 90%. However the uptake of training for other subjects including safeguarding adults and children for nursing staff was above 90%. Staff were aware of how to raise and manage safeguarding issues and there was a trigger system within the electronic patient record system to identify patients who may present with safeguarding issues. We found that compliance with this trigger system was variable. Staff did not always observe appropriate measures to protect patients from avoidable infections. We identified two patients who required isolation due to potential infections and they were not isolated, which put other patients at risk of contracting infection. Essential resuscitation equipment was checked inconsistently and not at the frequency required.

Medications were not always securely stored. We observed unsecured medications including medications for intravenous infusion. We found that a fridge used to store insulin and other medications was not locked on numerous occasions. Fridges used to store medications which required storage a particular temperature were not checked consistently. Some patients experienced delays in receiving important medications. The double checking of medications was not always undertaken in line with national guidance and trust policy. This meant that there was an increased risk of avoidable harm to patients.

Urgent and emergency services

Records were stored securely and managed using the electronic advantis ED records system. Patient's records were not always completed fully and contemporaneously. Some patient records did not contain appropriate detail and risk assessments.

Patient risk was not always assessed appropriately. In some cases patients had not been risk assessed for specific risks which applied to them. Patients were cared for and accommodated in areas which were not equipped or fit for this purpose. This led to an increased risk of avoidable harm.

Nurse staffing levels were not always adequate to ensure safe patient care. We found that patients routinely experienced delays in receiving care and treatment.

Medical staffing and skill mix was adequate. Staff were aware of the major incident policy and displayed a good understanding of their roles in event of a major incident.

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 on all incidents they raised.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). Seven serious incidents were reported to STEIS between November 2014 and October 2015. We reviewed the investigation reports for three of these incidents which resulted in harm to patients. We found that all three were appropriately investigated and the investigation reports contained all the relevant details pertaining to the incidents. In two of the three reports we found that actions which were recommended had not been completed by the date they were due. In one of the two six actions were not completed or updated and in the other case four of the actions were not completed or updated. These actions included actions related to sharing lessons learned from the cases.
- Learning from incidents was discussed within the monthly governance meeting. We saw evidence of lessons learned being discussed at these meetings and being cascaded to the monthly management and sisters meetings.
- There was a lead consultant responsible for reviewing all incidents and identifying themes and trends.
- Strategic data from the service showed that staff reported 222 incidents for the Unit between 1st July 2015 and 31st October 2015
- Some staff told us that they didn't always report extreme pressures and escalation as they felt this was a daily occurrence. This was evidenced in the strategic data provided by the trust which showed that between 1st July and 31st October 2015 only one incident was reported in relation to pressures on the department. This was despite the fact that staff told us that pressures on the department were frequently extreme and interfered with the daily running of the department. Throughout this period the service also consistently failed to meet the target of seeing 90% of patients within four hours.
- Staff were aware of duty of candourfor 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 saw evidence in three incidents that staff had appropriately exercised duty of candour and provided patients relatives with a leaflet explaining duty of candour. We found factual errors in one duty of candour letter.

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 was not recording data in relation to this initiative. However some data relating to avoidable harm was recorded and reviewed on a monthly basis including numbers of pressure ulcers and falls. Data for January 2016 showed that for both of these harms the department performed within expected ranges. The department were not recording and monitoring data in relation to CAUTI or VTE.

Mandatory training

- The uptake of mandatory basic life support was significantly lower than the trusts target of 90% for both medical and nursing staff. The training uptake for nursing staff was 52% and 41% for medical staff.
- Mandatory training on the mental capacity act was provided however the uptake of this training was below the trusts target for both the nursing and medical staff groups within the department. 82% of nursing and medical staff had undertaken this training. Training in this area is particularly important for staff working within an urgent care service due to the nature of patients who may present to the department. Patients often present to emergency department with an altered consciousness level and it is important that nursing and medical staff are trained and able to assess their mental capacity and understand their rights in relation to the mental capacity act.
- Manual handling training uptake was also lower than the trusts target for both medical and nursing staff at 75% for nursing staff and 82% for medical staff. This training equips staff with the knowledge and skills required to move and assist patients safely.
- Staff told us that they were encouraged to attend mandatory training but they could not always be released due to pressures within the department.

Safeguarding

- 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 team who could provide guidance and support to staff in all areas.
- The advantis system displayed triggers to staff in triage and at all stages of the patient's journey to consider safeguarding.
- We reviewed six children's records specifically in relation to the safeguarding trigger part of record and five of the six records had the safeguarding trigger section completed and one did not.
- We reviewed seven adults specifically in relation to the safeguarding trigger part of record and six out of seven records did not have this section completed and one record did.
- Safeguarding training provides staff with the knowledge and skills necessary to identify patients who are at risk of harm and abuse.
- The uptake for level 2 safeguarding vulnerable adults training for nurses was above the trust target at 91% for nursing staff. However the uptake for medical staff was significantly lower that the trust target at 35% for medical staff. Data provided by the trusts showed that 116 staff within the emergency department required level 3 safeguarding training. This data also showed that only 17 of these identified staff had undertaken this training giving a training rate of 15% which was significantly lower than the trusts target of 90%. The uptake for level 1 and 2 safeguarding children training for nurses were both above the trust target at 93%. The uptake of level 2 safeguarding children training for medical staff was 44% and 86% for level 2 safeguarding children training, both of which were below the trust target of 90%.
- The trust had recently changed their policy in relation to the level of training staff within the department were required to undertake, which had resulted in this low compliance figure. This had also been noted by the trust who had included this in their overall safeguarding strategy, however there was not an action plan to address this.
- Staff were able to explain the application of the law and their responsibilities in relation to female genital mutilation.
- There were appropriate referral processes in place for domestic abuse victims.

Cleanliness, infection control and hygiene

- We observed that cubicles and trolley spaces were not always cleaned between uses during busy periods. Patient debris were left on the floor between patients including used electrodes and tissues.
- We found that the decontamination room which was also used a deceased viewing room was visibly soiled with brown and red stains on walls and floor.We also observed that debris were on the floor in this empty room including electrodes and soiled tissues.
- Rates of hospital acquired infections within the department were l

- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance.
- We reviewed hand hygiene audit results for an eleven month period. This showed that for seven out of eleven months the department scored less than 90% in these audits. In three out of eleven months the department scored less than 1% in these audits as the data relating to the audit was submitted late. This means that less 1% of staff observed and audited washing their hands during these months did so in line with national guidelines.
- The department undertook early screening for infections including CPE during patient admissions. This meant that staff could identify and isolate patients early to help prevent the spread of infections.
- There were appropriate facilities including three individual rooms to isolate patients with a suspected infection.
- We observed two patients who presented with vomiting or diarrhoea that were not isolated appropriately and placed next to patients without infections. This was highlighted to staff within the department and appropriate isolation was arranged.
- The department had a comprehensive plan for the recent Ebola health alert.

Environment and equipment

- In the paediatric area the facilities were well maintained. The door from the main waiting area into the paediatric area was not routinely locked and this allowed unscreened access to the paediatric area from the main waiting room. The matron for the department confirmed that this door was not routinely locked and the paediatric area was accessible from the main waiting room at all times of day using a pad push system but was locked at night time. This issue had not been risk assessed and no control measures were in place to ensure that the paediatric patients were not able to leave undetected and also to prevent unauthorised individuals entering the paediatric area during day time hours.
- Appropriate equipment was available 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 two week period and all checks were fully completed for the period.
- In the main majors area of the department the resuscitation emergency trolley was not secured by a tamper tag system. The trust advised that this was because it was used so frequently. We checked this trolley and found low stock levels of needles, syringes and gauze. We also found that a size three oral airway was missing from this trolley; the UK Resuscitation Council recommends that essential resuscitation equipment should be checked on a daily basis. We reviewed the daily checklist for the resuscitation trolley and found that there was no documentation to indicate that it had been checked for 18 days in a two month period.
- We found that there were two defibrillators in the resuscitation area and one in the major's area which is in a different location in the department. We observed one occasion where the resuscitation room was at full capacity and a patient suffered a collapse. The staff had to leave the resuscitation area and retrieve the third defibrillator from the major's area to use with the collapsed patient. This led to a delay in the defibrillator being attached to the patient and also left the department with no defibrillators to use if another patient suffered a collapse.
- The admission route for patients was set up so patients arriving by ambulance were seen and triaged in a designated bay area by a designated ambulance triage nurse.
- There was an x-ray department situated next to the unit for easy access and also provided portable x-rays.

- The main waiting area in the department contained a large amount of seating, however at times of peak demand we observed that patients had to sit on the floor or stand as there was not sufficient seating.
- PAT testing was up to date for all electrical equipment we reviewed.
- Security staff were available on site 24 hours a day and were able to be contacted by telephone if needed. The 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.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps. We saw that waste was being segregated and disposed of appropriately.
- Bariatric equipment (specially designed equipment for obese patients) was readily available if required.

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.
- 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 observed one occasion where diamorphine was prescribed for a paediatric patient. The patient only required part of the dosage in the single use vial and therefore staff were required to discard some of the medication. The nursing staff carried out the appropriate checks to prepare this medication and discarded the surplus by placing it in a bin used to dispose of needles. The staff did not record how much of this medication was wasted and confirmed to the CQC pharmacy specialist that this was their usual practice. This was not in line with guidance on the management and destruction of controlled drugs.
- There were five fridges which were used to keep medications in the department. One was situated in the resuscitation area which was accessible by members of the public and staff without swipe access, 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 was locked securely when checked on three occasions.
- We found the fridge in the resuscitation area repeatedly unlocked on three out of five days of our visit. We highlighted this to senior staff in the department on all three days but the fridge was still found to be unlocked following this.
- The fridge in the resuscitation area contained insulin, intravenous infusions and medications used to sedate patients. The fridge was located very close to the unlocked entry door to the area and was easily accessible. We observed members of the public visiting their relatives in the resuscitation room on all five days of our visit.
- On two occasions we observed that staff were behind curtains administering clinical care so could not visualise the fridge and patients relatives were present in other trolley spaces. On one of these occasions we entered the resuscitation room and accessed the fridge and handled medications to check their expiry dates without being observed or challenged by staff in the resuscitation area. It is important that fridges are locked when they contain medication such as insulin, as if this medication were to be inadvertently or deliberately administered to a patient it could result in significant harm or death.
- We found that the daily checks required for the fridges in the emergency department were not undertaken on 18 days for the fridge in the resuscitation area. The daily checks were not undertaken for 13, 20 and 13 days respectively for the fridges in the locked medication preparation room.
- We also found oral medication left out on the side in the resuscitation area on two occasions. On both occasions we observed patients relatives present in the area. The medications on the side included medication for cardiac problems which could; if taken inadvertently or by the wrong patient cause them harm.

Urgent and emergency services

- The trust requires that all intravenous fluids are placed securely in a locked location to prevent the risk of tampering. We observed intravenous fluids unsecured on the side in the resuscitation area on two occasions. On one occasion the fluids were not in packaging and were left unattended for nine minutes. One the other occasion we observed that separate fluids were on the side and when we rechecked the area after 45 minutes and the fluids remained on the side.
- We found that all oral liquid medications were correctly labelled with an opened date apart from one bottle of morphine sulphate which did not have an opened date documented.
- We observed that administration of medications was delayed in some cases. In one case we observed a patient experience a one hour and 30 minutes delay in receiving their second in a set of three intravenous infusions. The infusion was being administered to counteract the effect of a medication overdose and should have been given in close succession. Staff told us that they the delay was because they did not have the capacity to complete the task at that time.
- We observed that a patient who was being treated for a severe infection experienced a delay of over four hours in receiving their prescribed antibiotics.
- Medications brought into the hospital by patients and their relatives were not always stored securely. We observed six patients with their medications loose or visible. In one of these cases the medications contained controlled drugs. We observed one of these patients leave the trolley space and leave their medication unattended at the end of their trolley.
- Some patients had their medications placed in a green zip lock bag. Staff within the department confirmed that this was the approved bag and system for securing medications in the department. These zip lock bags were left either at the patient's bedside or at the foot of their trolleys. This posed a risk of other patients or members of the public being able to take medications.
- An incident reported in September 2015 by the department outlined an incident where by a patient who had been admitted to the department with an intentional overdose had taken a further overdose while in the department as they were left with their medications unsecured.
- Three patients did not have their regular medications administered while in the emergency department. In one of these cases the patient was prescribed important medication for a cardiac condition and hypertension which were due to be taken in the morning. At 6pm the patient had still not received these medications. We reviewed the patient's notes and found that there was no clinical reason as to why the patient should not have received their medications.
- We found that medications which required a double check and signature by two nurses were not always completed correctly.
- We reviewed two records which showed that medications including one controlled drug had been signed to state that a staff member had administered them but the second check signature was completed 56 minutes later in one case and five hours later in another case.
- In both cases the staff member who had completed the second check was not on duty when the medication was prescribed. They had entered a note to say that they were signing for the medication as it had not been signed for by the appropriate staff and the electronic system would not allow any further entries without a second signature. This meant that there was no evidence that a second check had been completed for the administration of two controlled drugs and two other medications administered intravenously to patients. Second checking of high risk medications such as intravenous medications is important as it reduces the risk of any errors occurring which could lead to significant harm to patients.
- There were appropriate processes in place for ordering medications and stock reconciliation.
- We observed nurses administering medications to patients and they undertook appropriate checks when administering medication including checking the patient's name, date of birth and allergy status.
- 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.
- We reviewed patient group directions (

Records

- We reviewed 16 patients' electronic records during our visit. We found that records relating to patient treatment from medical staff and medical care were legible, easy to follow and completed fully. We found that patients nursing records were not always kept up to date and were not always completed fully.
- The department used electronic, computer based patient records and very few paper records. Records were stored securely and easily accessible to authorised staff via the advantis ED computer system.
- 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 three out of sixteen patients had no nursing records completed apart from their triage section. All three patients had been present in the department for a considerable length of time ranging between two and five hours. Two of these patients were awaiting inpatient beds.
- In 11 out of sixteen records we found that the nursing records were incomplete, examples included incomplete documentation of falls risk, pressure risk, pain score and intake of fluids.

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 designated nurse and triaged in a designated ambulance triage bay.
- 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. From July 2014 to July 2015, the department's median performance against this standard was about the same as the England average for this period.
- 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 the advantis ED system. This system alerted staff when observations were outside of accepted parameters.
- In nine out of 16 cases we observed 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 suffered a serious head injury and was awaiting a radiological scan of their head. This patient was placed in the corridor area and did not have observations taken for two hours. This was not in line with NICE guidance on the management of head injuries.
- Another patient was suffering from shortness of breath and chest pain and did not have any observations taken for one hour and 50 minutes. This was not in line with the trusts own EWS guidance.
- We identified another patient who was awaiting a medical bed who had not had any observations taken since admission one hour earlier. This patient was located in the waiting room.
- The department had a sepsis pathway in place and based on best practice and national guidelines. The advantis system prompted staff to consider sepsis and contained guidance on actions required in response to this condition.
- We reviewed two patients with a diagnosis of sepsis. One of these patients received timely care and treatment in line with the sepsis pathway.

- The other patient was identified at triage as being at high risk of sepsis and displayed two red flags. They did not receive timely antibiotics, fluids, high flow oxygen and senior review. These key interventions were delayed by two hours and thirty minutes. Records showed that the patient's observations deteriorated during this time. There was also no fluid balance monitoring completed which should have been completed in line with the sepsis pathway.
- We observed patients being accommodated in the main corridor of the department during all five days of our visit. The time these patients were resident in the corridor ranged from ten minutes to just over two 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.
- Senior staff within the department and within the medicine directorate told us that the corridor was only used to accommodate stable patients, who were not at risk of deterioration.
- We identified six patients who were acutely unwell and were accommodated in the corridor. Two of these patients were suffering chest pain of which one had displayed changes in the electrocardiogram (a test which can indicate damage to the heart) and required continuous oxygen therapy.
- One of the patients was in severe pain and was crying out and in a visibly distressed state.
- One of the patients suffered from dementia and had suffered a suspected severe head injury for which they were awaiting a radiological scan. One patient was very elderly and frail and had suffered a head injury due to a fall and one patient was vomiting profusely and suffering from severe pain.
- 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 their vulnerability and conditions. Six of the patients we observed in the corridor were physically unable to mobilise from the trolleys to seek help. During our visit we frequently observed patients in this area calling out for help and assistance.
- 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 five patients who were at risk of pressure damage and in four of these cases a pressure risk assessment had not been undertaken.In one of these cases the patient was not checked for over six hours and when they were checked a superficial break to their sacrum was noted to have developed in this time period.
- We observed three patients who were admitted with a history of falls. Two out of three of these patients did not have the falls risk assessment section of their records completed.
- We identified two patients who had presented with a history of self-harm and intentional overdose and both these patients did not have a self-harm risk assessment completed. Since the inspection the department have introduced a new Self-Harm risk assessment pro-forma that enables referral to mental health services and which they hope will improve completion rates. The department managers advised that all patients were risk assessed as part of the triage process.
- One of these patients was placed in a 'sub wait' cubicle for over five hours, which was not routinely used to accommodate patients for long periods. When we spoke with this patient they were low in mood and visibly upset. We observed that this patient was placed next to a patient with medications on their trolley.
- The second patient was placed back into the waiting room to await a medical bed. They also had low mood. We went to speak with this patient in the waiting room and initially could not locate them. They had left the department to make phone calls without informing staff and staff had not noticed that they had left.
- We found that blood sugar monitoring was not consistent and was not undertaken in all cases. We reviewed one diabetic patient's record and found that they presented with diabetes related problems but had not had their blood sugar measured on or since admission four hours earlier.

- We saw no evidence of a comfort round taking place to check if a patient needed water, access to the toilet, pain level or repositioning. We reviewed three elderly patients' records and found no evidence of comfort rounding in any of their records.
- All patients who presented to the department were seen and triaged by an appropriately qualified and trained nurse. Patients were either then asked to remain in the waiting area or could be moved onto trolleys in the majors or minors areas to be observed more closely. In eight out of ten patient records we reviewed patients had been triaged and seen by a nurse within 15 minutes of arrival to the department. There were significant delays in allocating patients trolley spaces.

Nursing staffing

- The staffing levels expected on a day time shift for the department were 12 registered nurses and three health care assistants. These levels of staffing were frequently not met. In a four month period we found that 54 out of 121 shifts were short staffed by at least one registered nurse. In the same period we found that 42 of 121 shifts were short staffed by at least one health care assistant. During this period the department requested bank staffing for 94 out of 121 shifts.
- On two of the five days we visited the department the staffing establishment was lower than planned. On one day there was one less nurse and one less health care support worker than planned and on another day there was one less nurse.
- Registered nurses were moved to other clinical areas on occasion, leaving the department short staffed. An incident reported by department in October 2015 outlined that staff had been moved from the emergency department on three dates. This incident outlined that patients experienced delays in receiving treatment on one of these days due to staffing levels in the emergency department.
- The vacancy rate for registered nurses was lower than the vacancy rate for medical staff at 4%. This means that 4% of nursing posts within the department were vacant at the time of our inspection. The annual turnover rate for nursing staff was 16.88%. This means that 16.88% of nursing staff either joined or left employment in the department within the year prior to our inspection.
- The matron told us that the expected ratio for staff to patients was one nurse to four patients in the major's area and one nurse to two patients in the resuscitation area. We observed times when these ratios were not met. The nurse who was responsible for the patients placed in the corridor was observed caring for between eight and ten patients in the corridor. These patients were all awaiting trolley spaces in the majors or resuscitation area. This meant that there was double the number of patients to one nurse than expected at times.
- Staff told us they were very busy and routinely felt that they did not have enough time to provide care and treatment to level they would like and were not always able to take their breaks when required. We observed numerous occasions where patient care was delayed as staff were busy and working within other areas. This included delayed observations; delayed assistance provided to patients to take them to the toilet and delayed medications.
- We observed that the staff in charge of the department and responsible for coordinating the shift were frequently required to work clinically due to the extreme pressures in the department. This left the coordinator and in charge role vacant for periods of time. We also observed the matron of the department working clinically to assist staff on all five days of our visit. This took her away from her day to day management duties.
- The department completed a twice yearly nurse staffing audit using a recognised workforce planning tool. The tool calculated the workforce and skill mix required to provide the nursing care needed in the department during the audit period.
- Staffing levels within the department were displayed on a board. The number of staff on duty was reflective of the duty rota
- We saw evidence that skill mix was considered when planning staffing. One example of this was the planning to ensure that staff trained in triage were available on each shift.

Medical staffing

- There was a 50% vacancy rate for consultant posts within the emergency department. This meant that the department had half the number of consultants they

required at the time of the inspection. Senior managers told us that they were working hard to recruit additional consultants and that this had been identified as a risk. The overall vacancy rate for medical posts was 19%.

- The medical staffing skill mix was not sufficient in some staff groups when compared with the England average. Consultants made up 20% of the medical workforce in the department which was 3% lower than the England average of 23%. However, there were
- 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.
- Junior and registrar grade doctors told us that they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed.
- 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 and also when additional reviews were requested by nursing staff.

We observed numerous patients waiting excessively long periods of time to see a doctor. This was due in the majority of cases to available space to see patients in the department.

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 it and showed a good understanding of the policy.
- There were designated store rooms for major incident equipment.
- Staff received major incident training.
- 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.
- The department also held easy to follow pocket guides and hand held radios which were to be used in the event of a major incident. There was a designated folder on major incident procedures available in the staff offices in the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

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 (CEM). The service participated in local and national clinical audits. In all national audits; areas for improvement were evident and identified by the trust. In two of the four audits completed the trusts failed to meet the required standard for the majority of the standards set out. Action plans were formulated following these audits and the monitoring of these actions was variable, with some actions not updated for over six months. The department participated in local audits and evidence of improvements as a result of these audits was provided by the trust.

Patients' nutritional and hydration needs were not always identified and were not always addressed appropriately. There was access to food and drink but the provision of this to patients was variable. Some patients did not receive timely analgesia. Data from national surveys showed that patients treated within the trusts had outcomes which were similar to patients treated in other trusts in England.

Patients received care and treatment from competent staff. The appraisal rate for nursing staff in the department was on an upward trajectory from 60% in May 2015 to 80.2% in

January 2016. Staff sought appropriate consent from patients before delivering treatment and care and appropriately considered the Mental Health Act where relevant.

The department had a team of highly skilled and competent nurse practitioners who complemented the medical staffing establishment. These practitioners were qualified to a high level and received regular and on-going support and supervision for their practice.

Evidence based care and treatment

- The emergency department used both National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to guide the care and treatment they provided to patients.
- A range of evidence based clinical care pathways were available and put in place for patients with relevant conditions. These included fracture neck of femur, sepsis, stroke and overdose of paracetamol. These pathways included prompts and treatment steps for staff to follow. Patients were 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.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.

Nutrition and hydration

- The department had facilities for making drinks and food including sandwiches were available if needed.
- We observed that some patients were offered food and drinks by staff members. However four patients told us that they and not been offered or provided any refreshments since presenting at the department. These patients had been waiting between one and five hours. Three of these patients approached the inspection team to ask for food and drink. Their requests were relayed to the staff in the department who provided them with refreshments quickly.
- Staff identified patients who were not able to eat and drink. In some cases patients were provided with intravenous fluids.
- We identified four patients who required their fluid balance recording and in three of these cases the fluid balance was incomplete. Two of these patients were at risk of dehydration and had received intravenous fluids; however this was not documented on the fluid balance chart. One of the patients was being treated for sepsis. The trusts sepsis pathway states that close fluid balance monitoring should take place in any diagnosis of sepsis including hourly urine monitoring. In this case the patient had no entries on their fluid balance and no record of their urine output.
- 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.
- We observed two patients in visible distress and crying out for pain relief. Both patients approached the inspection team and requested pain relief. One of these patients had been in the department for over an hour and had not been offered any 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 trusts scored about the same as other trusts of a similar size in England for all three questions in the A&E survey 2014.
- The trust participated in local audits frequently and the trust provided evidence of improvements to patients care as a result of these audits. One example of this was the audit of venous thrombo embolism prophylaxis in the department. Compliance with this assessment was 40% when audited. An additional mandatory field for

this assessment was added to the electronic records system and a simplified proforma was introduced. This resulted in a significant improvement in compliance with this assessment of 75%.

- The department participated in the national Royal College of Emergency Medicine (CEM) audits. CEM audits allow trusts to bench mark their practice against national best practice and encourage improvements.
- The trust participated in the asthma in children audit 2013/14. The trust scored about the same or better than other trusts in England for all standards in this audit.
- The trust participated in the national Royal College of Emergency Medicine (CEM) initial management of the fitting child audit 2014/15 audit. The trust scored 100% compliance with three of the standards in this audit. One of the standards which related to documenting an eye witness history scored 94% which was lower than the 100% target. The trust scored significantly lower than the 100% standard in the measure relating to provision of discharge information to parents. The trust scored 24% compliance against the 100% standard. An action plan in response to the areas which did not meet the standards were in place. These actions were all due to be completed by December 2015, but had not been completed by the time of our visit and there was no update recorded against these actions.
- The trust participated in the national Royal College of Emergency Medicine (CEM) 2013/14 severe sepsis and septic shock audit. The trust scored about the same or better than other trusts in England for all standards apart from two standards which related to the monitoring of capillary blood glucose and the administration of high flow oxygen. For these standards the trust scored worse than other trusts in England. An action plan in response to the areas which did not meet the standards were in place. These actions were all due to be completed by May 2015, but had not been completed by the time of our visit and there was no update recorded against these actions.
- The trust participated in the national Royal College of Emergency Medicine (CEM) 2014 Older People audit in relation to cognitive impairment. The trust scored 0% compliance in five of the six standards in this audit and 100% in one out of six. The areas which scored below the expected standard of 100% related to the assessment of cognitive impairment. An action plan was in place to address the areas for improvement, however the actions were not completed at the time of the inspection and the action plan had not been updated since June 2015.
- The trust participated in the national Royal College of Emergency Medicine (CEM) 2014 Mental Health audit. The trust scored below the expected standard of 100% for six out of seven standards. The areas which fell below the 100% standard related to assessment of self-harm risk, documentation relating to previous mental illness, the completion of a mental state examination, details of follow up and referral care, timely access to a mental health professional and facilities suitable to assess patients with a mental illness. The trusts scored 100% for one of the seven standards relating to the documentation of a provisional diagnosis. An action plan was in place to address areas for improvement, however the actions had not been completed at the time of the inspection and the action plan had not been updated since June 2015.
- The unplanned re-attendance rate for urgent care services within the trust within seven days was consistently lower than the England average between September 2013 and July 2015. This meant that less patients re attended A&E in this trust than others in England.

Competent staff

- We found that only 37.3% of nursing staff within the department had received their annual appraisal. This was below the trusts target of 90%. For the year April 2014 to March 2015 68% of nursing staff had received their annual appraisal. An appraisal gives staff an opportunity to discuss their progress and any concerns or issues with their manager.
- 93% of medical staff had received their annual appraisal which was above the trust target of 90%.
- The nursing and medical staff were positive about learning relevant to their role and development opportunities.
- Medical staff told us clinical supervision was available and they felt adequately supported.

Urgent and emergency services

- 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.
- All the Emergency nurse practitioners (ENP's)had degree or masters level education in autonomous practice and minor injury and minor illness care. ENPs were also supervised until they developed a clinical portfolio of evidence demonstrating the required knowledge and skills for safe and effective practice. They received regular feedback on their practice and had periodic supervision to ensure their clinical skills were maintained. They also had monthly clinical teaching from Consultants across the range of specialities they referred to.
- The Advanced nurse practitioners had all achieved a Master's Degree which was undertaken during a 2 year training programme which enabled them to develop the requisite skills for advanced practice in emergency care. They were supported by a Consultant mentor during training who then continued to provide on-going clinical support, education and supervision. They had regular departmental teaching to ensure they were up to date with national and local guidelines and evidenced-based practice. The training and development of the ANPs was also in line with Health Education England guidance for advanced practice in emergency care.

Multidisciplinary working

- We saw some evidence that there was effective communication and collaboration between multidisciplinary team members within the emergency department and other specialities.
- Two medical doctors; one senior and one junior told us that they felt that they were not always kept informed of the situation and status in the department. They told us that they would often be called to the department to assess and admit patients. They told us when they would arrive on occasion's patients would either be in the process of transferring to a ward or had already been transferred to a ward. We observed this happen on one occasion.
- 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.
- 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 with them most of the time. Some staff employed by an ambulance service told us that staff did not always communicate with ambulance crews waiting to handover patients during times of peak demand. They told us that they were not regularly updated as to how long the wait to handover would be. We observed one ambulance crew waiting to handover a patient for over one hour. During this time we observed the shift coordinator approach them only once to ask for the patient details and they did not provide any details on the wait time.

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.
- 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.

Urgent and emergency services

- 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.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff gave us examples of when patients lacked the capacity to make their own decisions and how this would be managed.
- 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

Data from the NHS Friends and Family Test showed that 90% of patients would recommend the Emergency Department at Stepping Hill Hospital to their friends and family. Patient's privacy and dignity was not always maintained. We observed occasions where patients were treated without curtains being drawn.

Some patients spoke positively about the way staff treated them however; some patients raised concerns with us about how they were treated and told us that they felt as if they were an inconvenience to staff.

Staff did not always have time to support patients and ensure that they knew what was happening. Patients comfort was not always maintained and we observed patients in visible distress on numerous occasions.

The viewing room for deceased patients was not fit for purpose and was not used by staff. As a consequence at one point during our visit there were two deceased patients in the resuscitation room at the same time as other patients were being treated.

Compassionate care

- Data provided by the NHS friends and family test (FFT) showed 21% of patients responded to this test which was a higher percentage of responses when compared to the England average response rate of 13%. This showed that 90% of patients, who completed the survey between May 2015 and November 2015, would recommend the emergency department at Stepping Hill hospital to their friends and family.
- 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.
- Four patients told us they felt that staff were too busy to support them; they also told us that they had come to expect this after previous attendances to the department and they felt the staff were always busy.
- One patient told us they felt alone and that they had not interacted with any staff member for over four hours. This patient was awaiting an inpatient bed and was waiting on a chair outside the resuscitation area for over four hours. They told us that they found sitting opposite the resuscitation room distressing due to the nature of the patients being treated in that area. When we reviewed the patient's records the last documented interaction with a staff member was 3 hours and 30 minutes earlier.

- We observed occasions where patients dignity and privacy was not maintained. Due to increasing demand on the department senior staff told us that they had installed holding areas in the corridors of the department to accommodate patients until a suitable trolley space became available.
- These holding areas were situated on the main through corridor of the department and paper curtains had been installed around them.
- We observed four patients in just their night clothes; including two patients with low cut night dresses being held in this corridor. Two of these patients told us they were cold, one of these patients was elderly and was seen to be visibly shivering. These two patients were situated in the corridor near the main door which allowed ambulance access. This door was frequently open and a cold wind was felt blowing through the area.
- 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. One patient told us they felt claustrophobic when these curtains were closed.
- We observed three patients receiving clinical care in this corridor area with the curtains open and the patient and procedure fully visible to members of the public and staff passing by. Two of these three patients were having intravenous cannulas inserted and blood tests taken and one was receiving a clinical examination and was fully clothed.
- One patient who was placed on a chair in this corridor area was vomiting profusely into a bowl without the curtains being drawn. This patient told us that they felt they had been treated like 'cattle' and that their dignity had not been maintained.
- The space around the trolleys in this area was extremely restricted, this led to the patients trolleys being frequently bumped into by passers-by including staff, other patients relatives and porters.
- The main electronic tracking screen for the department which displayed patient's full names and clinical status was situated in the middle of the department and was visible to members of the public attending the department. On two occasions we observed a relative of a patient reading the screen to locate their relative when it was unattended by the shift coordinator.
- The triage area situated in the main reception area was separated by a curtain. We observed that patients triage could be heard clearly from the waiting room including sensitive clinical details. When we spoke with one patient sitting near to the triage area they told us that they had overheard the triage process for other patients. Staff told us that there were private rooms available in the department to discuss sensitive issues, this was not advertised or made clear to patients in the waiting room or triage area.
- We observed two patients in visible distress and crying out for pain relief. The inspection team highlighted both patients to the nurse in charge immediately to ensure they received appropriate care.
- Three patients told us they felt that they had received excellent and compassionate care from staff in the department. Two out of these three patients told us that they felt staff had gone out of their way to help them and make them feel comfortable. Staff were observed to be treating patients with compassion and dignity in their one to one interactions with patients.
- 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 that curtains were closed around trolley cubicle areas in the major's area of the department when staff were providing care. There were private rooms available where staff could speak to patients privately if required, in order to maintain confidentiality.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a way they could understand.
- 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.

Urgent and emergency services

- 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 translation services and advocacy. Staff told us that they had access to advocacy and translation services if they identified this need.

Emotional support

- Most patients and relatives told us that staff supported them with their emotional needs. Three patients told us that they did not feel emotionally supported by staff. One of these patients had taken an intentional overdose and had low mood. They told us they felt forgotten by staff.
- 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 with brown stains to the floor and walls. There was a large drain in the centre of the room, a shower and decontamination equipment piled up on the outskirts of the room. There was a screen to cover the equipment if needed, however this screen was not large enough to cover the equipment and was visibly soiled with thick dust on the fabric. The room was clinical without any comforting features that may help relatives when experiencing such a difficult time. Staff told us that they tried not to use the room as a viewing room because they felt it was 'horrible'.
- We observed one occasion where two deceased patients were present in the resuscitation area for over one hour. At this time there were also patients receiving active treatment in the adjacent trolley spaces. We observed that the curtains shielding one of the deceased patients were slightly open and the deceased patient was visible from outside the trolley space. Members of the public were able to enter the resuscitation area to visit their relatives.
- An incident was reported by department staff in July 2015 referenced the same issue regarding adequate space to place deceased patients and support their relatives. In that case there were two deceased patients in the resuscitation room with no suitable place to accommodate the relatives of the second patient.
- One patient who was awaiting an inpatient bed outside the resuscitation area told us that they were upset by the scenes they witnessed in relation to the resuscitation area. They told us that they were situated next to a grieving family at one point during the time they were waiting.
- Chaplaincy services were available on site and staff were able to tell us how they would access these for patients.
- There was a private room available for patient's relatives to wait when patients were very unwell or deceased. This room 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 found that the trust had made some efforts to understand the needs of the local population and adapt services to meet their needs. 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 on all days of our visit. Ambulances were frequently queued in the department corridors and handovers were often delayed, on occasions these handovers were delayed over 50 minutes.

There was a separate paediatric department which was well equipped to deal with paediatric patients. Patients in the paediatric area experienced minimal waits to be seen and referred to appropriate specialities. The department

had implemented a community assertive in reach team (CAIR) who worked to facilitate the discharge of elderly patients from the department by implementing additional support and care at home.

The department also had a designated hyper acute stroke unit which was used to treat patient presenting with symptoms of stroke. This unit was observed working very effectively with competent staff providing excellent care to this group of patients. A full time alcohol liaison nurse was employed by the trust and was based in the department.

Patients in the adult department routinely experienced excessive and unacceptable waits to see a clinician and in allocation of inpatient beds. The trust consistently failed to meet the four hour arrival to face to face consultation target. Patients were routinely 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 no means for patients to call for help and assistance.

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 not always follow the guidance and actions outlined in this policy which led to delays in space becoming available in the department. The clinical decision unit and medical assessment unit were routinely used to outlie medical patients. This meant that the flow of patients through the units was impeded frequently which resulted in the department not being able to use the spaces in these units.

However, the department had a competent team of advanced and emergency nurse practitioners who saw a range of patients and helped to ensure patients received timely care and treatment.

Service planning and delivery to meet the needs of local people

- Throughout our inspection the department was overcrowded and on multiple occasions there were not sufficient trolley and cubicle spaces. At these times of peak demand ambulances queued in the departments corridors and outside.
- 20% of the patients attending the emergency department were under the age of 16. In response to this the trust had developed a designated paediatric area which was separated from the main department. This area contained all relevant equipment required for treating children.
- There was a large local population of elderly patients in the Stockport area. The trust had adapted their services to meet this need through the implementation of a community assertive in reach team (CAIR). This team assisted in facilitating discharges from the emergency department through community in reach. This included the implementation of occupational therapy and physiotherapy to enable patients to be discharged from the department safely.
- The department also used a pathway when caring for patients with dementia. This pathway would travel with the patient through their inpatient journey and ensured that these patients received evidenced based, well planned care.
- The department had a link nurse with a specific responsibility for equality and diversity. This nurse role was to disseminate any relevant developments or news in relation to the equality and diversity agenda.
- We spoke with three staff from ethnic minority background. All three staff told us that they felt supported in their roles and had not been discriminated against in the course of their employment.

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.
- 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.

- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).
- Staff told us that some patients attending the department lived in poverty and some patients were homeless. As a result of this the department was working with local food banks and provided patients who required this type of help with vouchers to take to their nearest food bank to obtain food.
- A full time alcohol liaison nurse was employed by the trust and was based in the department. This nurse worked specifically with patients attending the department with alcohol related problems screened patients on weekly and monthly basis to ascertain any patients who may benefit from his support. Staff within the department were able to flag up patients to this nurse using the advantis ED computerised records system. Staff told us that the alcohol liaison nurse was in the process of developing a specific pathway to allow ambulance staff to refer patients directly to the nurse to prevent unnecessary hospital admissions.
- The department also had a designated hyper acute stroke unit which was used to treat patient presenting with symptoms of stroke. This unit was observed working very effectively with competent staff providing excellent care to this group of patients. The ambulance service would alert the department when they were bringing a patient to the department with any signs of a stroke. This specialised team was then alerted through the hospital alert system and attended the department. The unit had a designated porter to ensure that patients were transferred without delay if they required radiological interventions in another area of the hospital.
- We observed two patients being treated in this unit receiving outstanding care. One patient was assessed, had relevant clinical tests including blood tests, CT scans of their brain and began life saving treatment within 15 minutes of their arrival in the department. The more quickly a patient receives treatment for a stroke the better their chances are of making a successful recovery. Throughout this rapid process the staff kept the patient and their family informed of all progress.
- There was not any specific guidance to assist staff on how to support patients with a learning disability.

Access and flow

- There is a Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival. From November 2014 to November 2015, the trust only met this target for two months out of twelve. For three out of these twelve months the department saw less than 80% of patients within this four hour target.
- From August 2014 to August 2015, the percentage of emergency admissions waiting four to 12 hours from decision to admit until being admitted was variable when compared to the England average. The trust performed better than the England average for seven months out of twelve, about the same as the England average for three out of twelve months and worse than the England average for three out of the twelve months. In December and January 2015 the trust performed significantly worse that the England average with 20% and 30% of patients respectively waiting between four and twelve hours to be admitted.
- Strategic data showed that the percentage of patients leaving before being seen was consistently worse than the England average, apart from September 2014 where the trust performed about the same as the England average and May 2015 where the trust performed better than the England average.
- From July 2013 to July 2015, the total time patients spent in the emergency department (average per patient) was consistently higher than the England average. This means that on average patients spent more time in the emergency department at Stepping Hill Hospital that at other trusts of a similar size across England.
- There were 199 black breaches from November 2014 to October 2015. 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.
- The department had a specific ambulance triage cubicle to assess ambulance patients with a designated senior nurse staffing this cubicle. During the inspection we observed two occasions when this cubicle was used to accommodate patients already within the

department and not patients from ambulances. This was due to increased demand within the department and lack of available trolley and cubicle spaces. As a result ambulance staff waited in the corridor with patients.

- We spoke to five patients in the waiting room who had been waiting between one and six hours to be seen. All five patients had been triaged within 30 minutes of their arrival. Two of these patients told us that they had come to expect very long waits at Stepping Hill Hospital.
- We spoke with two patients in the waiting room who were awaiting inpatient beds.
- One of these patients told us that they was incredulous that they had been deemed unwell enough to warrant a hospital admission and were then placed back into the waiting room. They told us that the staff had not taken their observations and had not spoken to them since their triage. When we reviewed the patient's records these showed that the patient was being admitted via their GP and no observations had been taken and there was no documented interaction with staff following the patient's triage.
- We reviewed the notes for eight patients who had arrived by ambulance. The time to initial assessment was between 10 and 124 minutes.
- Staff told us that the department was consistently busy and lacked capacity to accommodate incoming patients.
- Senior staff within the department told us that areas within 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 any length of time.
- We observed the department lacked capacity to accommodate patients on all five days of our visit.
- On three of the days of our visit the resuscitation area was to full capacity and could not accept any further patients. The time that the area was full ranged between 30 minutes and four hours. This meant that if a patient was to be admitted either by ambulance or through the department waiting room with a life threatening condition requiring resuscitation, they could not have been accommodated in the resuscitation area.
- We observed patients being accommodated in the main corridor of the department during all five days of our visit. The time these patients were resident in the corridor ranged from ten minutes to just over two hours.
- The corridor was not equipped with the same equipment you would find in a designated emergency department space including piped oxygen and suction, which may be required in an emergency situation.
- Senior staff within the department and within the medicine directorate told us that the corridor was only used to accommodate stable patients, who were not at risk of deterioration.
- We identified six patients who were acutely unwell and were placed in the corridor.
- 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 observed the department trigger the red escalation status on three of the five days during our visit and trigger the black escalation status on two of the five days during our visit. On all five occasions when we observed the department trigger red and black status, we saw that the actions set out in the internal emergency department escalation policy were not followed.
- One of the key actions listed in the red and black status action cards was that a 'huddle' should be instigated within the department if the number of patients

reached 45 or more. This huddle should have included the Coordinator, bed manager, ED consultant and ED Matron. On two of the five occasions this huddle was not completed.

- Another key action listed in the red and black status action cards was for staff to ensure that clinical care is maintained by staff and that patients are appropriately nursed for example on beds not trolleys while waiting for an inpatient bed. We observed that two patients who were in the department waiting for an inpatient bed had not received their regular medications. We also observed one patient who had suffered a fractured hip and had been in the department for over nine hours. This patient was still on an emergency department trolley and had only had their pressure areas assessed once in this time at which point skin damage was noted.
- In the black status action card which was to be followed in the event of the department reaching this level, the actions stated were attending black alert meetings, activate the full capacity protocol and develop contingency plans using the decision making model as a tool. On both occasions the staff in charge of the shift had not identified that the department had met the criteria for black status and had not undertaken key actions outlined in the action cards. When we highlighted this to them they initiated some of the actions outlined in the action cards.
- On one of these occasions we observed a senior staff member trying to contact the matron by telephone with no success; they also tried to contact the senior manager for the business group twice with no success.
- At this point in time there were over 50 patients in the department with ambulances waiting in excess of 50 minutes to hand over and no capacity in the resuscitation area.
- There were nine patients waiting in the corridor and the nurse allocated to that area had been moved to provide clinical care in the major's area.
- The sister in charge was also providing clinical care due to the excessive demand on the department.
- During this time we observed that patients were experiencing delays in receiving pain relief, observations and pressure care.
- During this time we attended the patient flow manager's office to track what action was being taken by senior staff external to the department. The patient flow manager was not aware of the status of the department and confirmed that neither was the manager or director on call as they had not been contacted by the staff or matron in the department.
- When we asked the senior staff working on the shifts when the department reached black status how they would activate the full capacity protocol listed in the department's internal escalation process, they could not articulate to us how they would do this, one member of staff told us that they were not aware of what this was.
- We observed that patients were not always moved to inpatient beds as they became available. We observed 16 patients who had been allocated inpatient beds but had not been transferred from the department.
- The delay in transferring these patients ranged between 15 minutes and two and a half hours. At the time of the bed allocations the department was under extreme pressure and was holding patients with ambulance crews and in the corridor spaces. When we asked the shift coordinators why the patients had not been moved they told us that two patients had a clinical need which required them to be in the department. We observed that one of these patients had their clinical need met and was still not moved for a further one hour. In relation to the other patients we were informed that there was a lack of staff to undertake transfers. The shift coordinators however confirmed that some of the patients did not require a nurse escort. We observed that portering staff were available at these times and visible in the department.
- The emergency department live tracking screen was not always updated with current patient locations. We observed delays of up to 16 minutes in entering patient's correct locations. This led to some confusion as to patient location and we observed two occasions where relatives could not locate patients. Staff who worked within the corridor area told us that this sometimes led to a chaotic environment and they would sometimes not be aware of who the patients were in the corridor or their needs. Ambulance staff also told us that they found the corridor area organisation and management chaotic at times.

- Some senior nurses in charge of coordinating shifts in the department told us they sometimes felt abandoned by staff external to the department in relation to patient flow and in times of increased demand. They also told us that they frequently felt the department was unsafe at these times of peak demand.
- All staff we spoke with told us that they were worried about the capacity of the department and patient flow.
- There were bed meetings held three times a day and led by the director of the day. These meetings were attended by senior nursing staff from the ward areas, patient flow team and the emergency department team. We attended three of these meetings and found that they were well structured and aimed to improve patient flow; however information around discharge times and anticipated bed numbers was not specific. One example of this was the use of terms such as some beds would be available and the possibility of some 'back end' beds with no specific time frames or targets to make the beds available. In one of the three bed meetings there was no representative from the emergency department until the meeting was closing.
- The patient flow manager was a visible presence in the department during our visit and was observed assisting staff in the management of increased pressures. Staff within the department told us that the patient flow manager would frequently attend the department to assist staff during times of increased pressure.
- Senior nursing staff in the department were not routinely aware of when exactly they could expect inpatient beds to become available and the numbers of these beds.
- The department had a clinical decision unit (CDU) which is used to accommodate emergency department patients who are awaiting clinical decisions or require additional periods of observation. This would potentially prevent unnecessary admissions to the acute inpatient wards and ensure that patients are treated in the most appropriate environment. When we visited the CDU we found that the unit was being used exclusively to house medical patients as outliers. Two of the patients had been on the unit as an outlier for three days. One of these patients was clinically unstable and suffered an episode of acute chest pain while we were present. This patient had been diagnosed as having an acute cardiac condition. We raised this with the director for the medical division and a transfer to the coronary care unit was arranged.
- Staff within the CDU told us that medical patients were accommodated on both the CDU and the adjacent medical assessment unit (MAU) frequently and were not always stable. Staff told us that patients would also be placed in the adjacent MAU overnight at times although senior managers did try to only use that area as a last resort. This overnight use was confirmed with a senior manager within the medicine business group. The standard operating procedure for the MAU stated clearly that patients should not be accommodated overnight in the MAU and if this occurred it should be treated as a 'never event'. We found no 'never event' reports in relation to this despite this being stipulated. Staff within the CDU told us that this severely impeded the flow of patients through the emergency department as the CDU and MAU could not be used at these times to see, treat and discharge patients which alleviated the pressure on the emergency department.
- We observed one female patient who was placed in a curtained cubicle between CDU and MAU to await a medical inpatient bed. This patient had been in the unit for over 24 hours. They did not have a locker to store their belongings and told us they were uncomfortable with men frequently passing their cubicle. They also told is it was very noisy and they struggled to sleep, we observed that the environment around the patient's bed space was very busy and noisy at times.
- We asked a senior manager to explain to us the process for outlying patients to the CDU and they advised that it would only be undertaken as a last resort. We asked this manager to explain what the priority system was to re-accommodate medical patients on CDU and they were unable to articulate whether there was a priority system or what the maximum time was that a patient could be outlied to the CDU.
- We observed two patients occupying trolley spaces in the emergency department who would have met the criteria to be moved to the CDU. One patient had received sedation and required an area to be observed for a number of hours and another patient had sustained a head injury and required a period of observation before discharge. Neither patient could be

accommodated on CDU due to the presence of medical outliers. One of these patients suffered from dementia and was visibly distressed by the business of the emergency department. Therefore the CDU which was a quieter environment would have been more suitable for them. Senior clinicians in the department told us that the issue of being unable to use CDU due to the presence of medical outliers was a frequent problem for them.

- The standard operating procedure for the CDU stated clearly that medical patients should only be accommodated in the CDU when all other bed capacity within the hospital had been used. This standard operating procedure also stated that only patients with an estimated date of discharge within 24 hours should be accommodated within the CDU. This was not being adhered to as we observed two patients who had been accommodated on the CDU for three days at the time of the inspection.
- We observed numerous patients experiencing unacceptable waits to be seen and allocated inpatient beds.
- The trusts held a daily meeting with social care agencies, age UK, discharge coordinators and director of the day to try and address and progress any issues of delayed discharges.
- Patients raised concerns with us prior to the inspection about patients being sent to ward areas and being placed in non-clinical areas while awaiting an inpatient bed. Staff told us that patients who were awaiting inpatient beds were sometimes sent to ward areas to be accommodated in non-clinical areas during times of extreme pressure in the Emergency Department. This was confirmed by a senior manager within the trust. The trust called this process 'boarding'. At the time of the inspection the trust did not have a policy or standard operating procedure to guide this practice and mitigate the risks associated with this practice.
- Since the inspection the trust have implemented an action plan and policy to address some of the issues associated with this practice such as patient experience and access to equipment including oxygen and suction.
- 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". This service managed over 20,000 patients per year to an extremely high standard with low rates of un-planned follow-ups. 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 number of Advanced Nurse Practitioners (ANPs) who assessed, examined, diagnosed and treated the whole range of patient presentations in the department. This service was developed as part of the workforce plan.

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 trust recorded complaints on the trust-wide system.
- We reviewed three completed complaints which related to the emergency department. These complaints had been investigated thoroughly and the responses to the complaints contained sufficient detail. The responses to these complaints were provided to the complainants in a timely way in all three cases.

Are urgent and emergency services well-led?

Requires improvement

We found that the department was not well led at all times and the leadership did not always ensure the delivery of high quality person centred care. The medical leadership within the department was clear and strong.

Not all staff could articulate the current strategy and vision for the service. Monthly governance meetings were held and were attended by senior staff. There was no specific emergency department risk register but risks relating to the department were recorded on the business group risk register. Risks were not always appropriately identified, monitored and there was not always evidence of action taken where appropriate.

Urgent and emergency services

Staff spoke positively about their leaders and told us they were visible and staff felt able to able approach them. Staff told us the culture within the service was open. Staff did not always feel supported by senior managers external to the department and felt they were not always visible at times of peak demand. However staff told us that the chief executive and other executive team members were a visible presence in the department on a regular basis.

Managers made efforts to engage the public when planning services and had an active service user group.

Vision and strategy for this service

- Only two of the staff we spoke with could articulate the current strategy and vision for the service.

Governance, risk management and quality measurement

- The department was part of the medicine business group. Each business group was headed by a clinical lead, supported by a divisional general manager and head of nursing. A governance lead was also identified in the department at consultant level.
- Monthly governance meetings were held, attended by the clinical director, management and senior nursing staff. Items covered included workforce, risks, health and safety, effectiveness, complaints and lessons learnt.
- The emergency department did not have specific risk register but risks relating to the department were recorded on the business group risk register.
- The register identified risks but did not include details of control measures to mitigate them or target dates to meet them.
- The register reflected some of the current risks the department had identified, for example compliance with the four hour performance target. However some significant risks identified within the department were not present on this register. One example of this was the risk to patients being accommodated in the corridor of the department which posed a significant risk.
- Another risk which was not listed was the reduced number of consultants within the department. Senior managers within the business group told us that this was a key challenge for the department however this was not listed on the risk register and therefore there was no evidence that any control measures were in place to mitigate this risk.
- All five risks on the risk register were past their date for review. One of these risks related to serious concerns raised by external peer reviewers in relation to trauma care in the department. This risk was categorised as having a risk score of 20 and an action plan was in place. This action plan had not been updated since November 2015 despite the high risk grading.
- There was a system in place that allowed managers to escalate risks to divisional meetings.
- Audit and monitoring of key processes took place in the department to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives.

Leadership of this services

- Staff told us that they felt well supported by their seniors.
- The matron for the department was routinely absent from management duties to deliver clinical care in the department. This affected the matron's ability to undertake her management role. One example of this was the significantly low rate of appraisals for nursing staff within the department at 37.7% at the time of inspection and 68% in the previous year and the low uptake of mandatory training for nursing staff in some subjects.
- Two senior nursing staff within the department told us that they did not always feel supported by the wider senior team outside of the emergency department. They told us that they sometimes felt abandoned by senior managers.
- During our visit the matron for the department was visible in the department delivering clinical care and staff told us that this was usual.
- On one occasion the department had reached black status (the highest) on their internal escalation process. The shift coordinator was witnessed attempting to contact the matron and senior manager with no

success. At this time the shift coordinator appeared visibly stressed and was assisting other nursing colleagues with clinical care due to the pressure on the department at that time.

- The matron of the department told us that she felt well supported by the head of nursing and business group director.
- Staff told us that they saw members of the executive team regularly in the department including the chief executive. The staff told us that they frequently saw the chief executive when she was on call during out of hour's periods. Staff spoke positively about the chief executive and told us that she often assisted them, that she was approachable and they felt supported when she was present in the department. We observed the chief executive in the department during one out of hour's period supporting staff and speaking with patients.
- Staff employed by an ambulance service told us that during periods of extreme pressure they had observed directors and managers on call in the department. They advised that they felt they did not always offer meaningful assistance and reported that some managers and matrons had a nonchalant attitude to the pressures and verbalised that there was nothing they could do as the hospital did not have sufficient inpatient beds.
- Staff spoke positively about the clinical lead for the department and told us that he was approachable and visible. We observed clear clinical leadership from the consultants and clinical lead in the department.
- Medical staff told us their senior clinicians supported them and they had access to senior clinicians when they required. Medical staff were able to tell us who the medical director was and spoke highly of him.

Culture within this services

- Staff told us they felt respected and valued.
- All staff told us that they felt secure raising a concern or issue with their managers.
- We observed that the culture was focused on patient flow and movement and not always on the quality of care provided to patients.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The department participated in the NHS friends and family test, which gives people the opportunity to provide feedback about care and treatment they received. Information on the results of the NHS Friends and Family test were available for patients and staff to view.
- The department had an active service user group who were able to feed back any changes or improvements to senior managers.

Staff engagement

- Staff told us received regular communication from their managers.
- A monthly newsletter was produced and distributed to all staff. This newsletter included lessons learned from incidents and complaints and reminders of standard protocols.
- Staff participated in team meetings on a monthly basis.

Innovation, improvement and sustainability

- We saw evidence in business plans and strategic objectives including a winter pressures plan and a 90 day plan. There was evidence that leaders had assessed the sustainability of these plans and improvements.
- The department also had a designated hyper acute stroke unit which was used to treat patient presenting with symptoms of stroke. We observed outstanding practice in this unit where patients were assessed and treated rapidly by competent specialists. This increased their chance of treatment and ultimately maximised their chance of recovery from a stroke.
- The medical assessment unit was another example of innovative practice within the department. This unit had been developed and opened to reduce the numbers of inpatient admission and ensure that patients received the appropriate level of care. When this unit was open and used for its original purpose we observed patients receiving care and being discharged when they would have otherwise required an inpatient bed. Unfortunately this area was frequently used to accommodate patients awaiting an inpatient bed which impeded the utilisation of this innovative initiative and flow through the department as a whole.

Urgent and emergency services

- The department had implemented a comprehensive team of nurse practitioners to complement the medical staffing establishment. This was undertaken after identification of local and national recruitment challenges in relation to emergency care doctors. This team of practitioners helped ensure patients received timely, evidence based care and treatment and helped alleviate the pressure on the medical staff within the department.

Medical care (including older people's care)

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

Information about the service

Stockport NHS Foundation Trust was one of the first ten Foundation Trusts in the country. 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.

Stepping Hill Hospital is the Trust's main acute site which provides emergency, surgical and medical services and is accompanied by 17 community sites and 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 19-22 January 2016 and an unannounced inspection took place on 01 February 2016.

During our visit we inspected wards A3, A10, A11, A12, A14, AMU, short stay older people, endoscopy, day hospital, B2, B4, C4, E2 AND E3 , reviewed 51 sets of records, talked to 12 patients and 52 staff members including nurses, doctors, pharmacists and therapy staff.

Summary of findings

We found medical services at Stepping Hill hospital Required improvement because:

- There were high nurse and medical staff vacancies within some areas of the service which required prompt recruitment action.
- Gaps in shifts and rotas were filled by agency and bank nurses and locum doctors on a frequent basis. We found that this resulted in an inconsistent skill mix and some areas were left with inexperienced staff.
- Although the wards were adequately staffed at the time of our inspection, the reliance on bank and agency staff on some wards and departments meant that this was not a sustainable position. Staff also told us that they 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 care for the type of conditions patients had.
- The mandatory training completion rates for both medical and nursing staff were below the expected target and in some cases were significantly lower than the trusts target. One example of this was that only 55% of medical staff had undertaken the mandatory training they required.

Medical care (including older people's care)

- As a result of bed pressures medical patients were often placed on surgical wards. This led to patients receiving care from staff who were not experienced in caring for their specific clinical needs and conditions.
- In August 2015 there were 193 medical patients placed on surgical wards and 207 in September 2015.This meant that this group of patients were not always placed in areas best suited to their needs. Patients experienced a number of moves during their stay. Significant numbers of patients experienced 3 or 4 moves during their admission.
- There were a high number of patients who were experiencing delayed discharge and remained in hospital longer than they needed to be. This increased pressure on the hospital as a whole and also made patients vulnerable to hospital acquired infections and other conditions related to an extended length of stay in hospital such as blood clots.

However

- Incidents were reported and lessons learnt shared amongst staff.
- Staff knew how to access the incident reporting system and could tell us about incidents they had reported.
- Risk assessments were completed and staff implemented measures to reduce risks.
- The environment was clean and tidy and staff had access to the equipment they required.
- Medicines were managed safely and stored securely within the medical division.
- Services worked in coordination with partners and patients were appropriately referred to specialist services.
- Staff treated patients with respect and dignity, offered support and included them in care planning.
- Patients received a caring service and staff discussed treatment plans with patients to ensure a person-centred approach.
- Services were planned to meet the needs of the local population and included national initiatives and priorities.
- The trust 18 week referral to treatment times were better than the England average between September 2014 and August 2015, except for a decrease in January 2015.
- Risk registers were in place and discussed at team meetings.
- Staff were aware of the trust's values and vision.
- Staff felt well-supported by managers and colleagues.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated the medical services as 'requiring improvement 'in the 'safe' domain because.

- There were areas of high vacancy rates for nursing and medical staff within the service. Gaps in shifts and rotas were routinely filled by agency and bank nurses and locum doctors. This led to an insufficient skill mix of staff in some areas.
- Although the wards were adequately staffed at the time of our inspection, 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 complex clinical needs of patients in these areas.
- The number of shifts filled varied greatly between ward areas from 56.5% in one area to 99% in another area. This meant that there were not always the numbers of registered nurses on duty to meet the needs of the patients in these areas.
- Sickness rates within the division were high in some areas and specialities at up to 14%.
- The mandatory training completion rates for both medical and nursing staff were below the expected target and in some cases were significantly lower than the trusts target. One example of this was that only 55% of medical staff had undertaken the mandatory training they required.
- Only 80% of staff who were required to undertake mandatory training in safeguarding children had undertaken this training.
- There was variable compliance across the service in relation to hand hygiene , audits which were completed showed compliance varied between 92.3% in July to 71.8% in October 2015 showing inconsistency and an overall downward trend
- We found that records trolleys used to store patients confidential records and sensitive information were unlocked which meant they were potentially accessible to the general public.

However

- There were systems and processes in place to protect patients from avoidable harm. There was an Early Warning System in place to promptly identify changes in a patients condition.
- Staff knew how to report incidents and could give us examples of incidents such as pressure ulcers and falls. Staff were aware of 'Duty of Candour' (and felt confident to practice this. The care environment was clean and tidy. Equipment was clean, routinely serviced and ready for use.
- Medicine storage was secure and accurate logs and records maintained.
- The trust utilised electronic and paper based records..
- We reviewed 14 sets of records and found they were of a good standard and all risk assessments were fully completed. Records were legible, signed and dated.

Incidents:

- Incidents were reported using an electronic system and in October 2015 a total of 376 were reported across the medical business group.
- There were no never events reported in relation to medical care . A 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.
- Staff could access the system and knew how to use it, they told us the types of incidents reported and these included pressure ulcers, falls and staffing issues
- Trust wide there were 70 serious incidents reported across medical services between October 2014 and November 2015. 20 of these were due to health care acquired infections (HCAI).
- Root cause analysis was undertaken to investigate incidents and these included a timeline of events, identification of issues and action plans to identify and implement improvements required.

- Feedback regarding incidents was given at team meetings and that lessons learnt discussed and implemented.
- Staff confirmed that they received lessons learnt feedback at team meetings and via information boards. They gave examples of changes made from incidents and this included the formulation of a new handover sheet being introduced.
- Staff understood the term 'Duty of Candour'. Duty of Candour 'as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred the registered person must notify the relevant person that the incident has occurred and provide reasons to support to the relevant person .
- Serious incident investigation reports showed the duty of candour process was followed and patients and there families were informed at an early stage. Patients were given a leaflet about the duty of candour process.
- The trust provided Duty of Candour training as part of incident investigation training.

Safety thermometer:

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. NHS Safety Thermometer data reported between December 2014 and December 2015 showed 22 pressure ulcers, 22 falls that resulted in harm and 12 catheter acquired urinary tract infection (CAUTI).
- The safety thermometer was monitored via the nursing dashboard with subsequent action plans developed . These 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:

- All areas we inspected were visibly clean and tidy.
- Hand gel and personal protective equipment was accessible on each ward and was utilised by staff and visitors.
- We observed that staff washed their hands and were bare below the elbow during and between interventions and tasks.
- Staff reported being aware of the current infection control procedures and guidelines and could access them via the intranet. Arrangements were in place for the safe handling, storage and disposal of clinical waste and sharps.
- Sharps bins inspected were signed and dated, and partially closed when not in use.
- From April 2014 to November 2015 there were 36 cases of C.Difficile reported across the medicine division and 2 cases of MRSA.
- The key issues report for October 2015 to the planning and performance board showed that from April 2015 to October 2015 there had been 16 cased of C.Difficile 23% of which had been reported on ward A11. Infection rates were monitored by the monthly quality governance board minutes from the November 2015 quality governance board meeting showed prevalence of C.Difficile was highlighted as an issue ,actions taken included planned deep clean of several wards including A11 a planned meeting with regard to a lack of side rooms and a poster being shared across all wards to increase staff awareness. However there were no timescales for completion recorded.
- Hand hygiene audits were completed monthly and results showed varying compliance with an average compliance of 92.3% in July to 71.8% in October.2015 showing inconsistency and an overall downward trend
- There was an action plan in place for each ward

Environment and equipment:

- The hospital has been higher than the England average for the Patient-Led Assessments (PLACE) from 2013-2015.
- Equipment was routinely maintained and serviced. We observed green 'I am clean' stickers displayed on equipment that indicated that they were clean and ready for use.
- Daily checks of resuscitation trolleys and logs were completed and up to date. Equipment was serviced and in date.
- 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 manufactures guidance including portable appliance testing (electrical equipment)

Medicines:

- Controlled drugs were stored in locked cupboards and logs reviewed showed they were checked daily.
- Recording of daily drug fridge temperatures showed they were within the optimum range of between two and eight degrees.
- Drug trolleys observed were secured to the wall when not in use. We checked three random drugs in each trolley in use and all drugs were in date. We also checked 44 prescription charts which were fully completed, legible and signed.
- There was recording of allergies on prescription and nursing assessment documents.
- Wards had hypoglycaemia boxes available for the treatment of patients with a low blood sugar level and all stock inside the boxes was in date.
- Staff had access to medicine management training as part of the mandatory training programme.

Records:

- The hospital utilised electronic and paper based records. These were in the form of nursing records and medical case notes.
- People had their needs assessed on admission and care plans formulated with review dates. The hospital audited records for compliance to record keeping guidance.
- The record trolleys that were inspected were unlocked which meant they were potentially accessible to the general public.
- Records were legible, signed and dated, however name and designation was not always clear or printed. Nursing notes were kept at the bedside and medical notes kept in record trolleys.
- We reviewed 14 sets of records and found they were of a good standard and all risk assessments were fully completed.
- There had been an improvement in the completion of EWS following the implementation of a new electronic form. Early warning scores were completed for all patients. The trust audited completion of these prior to the introduction of electronic recording system and following introduction. Compliance pre-patient track (2013/14) was between 53 – 98% and completion post patient track (2014/15) is 100%

Safeguarding:

- The trust had safeguarding policies and procedures in place and had allocated leads for safeguarding adults and safeguarding children.
- The safeguarding leads were able to provide advice and guidance for staff when there were issues of concern.
- Online training was available for safeguarding training level one and two.
- Staff knew how to refer to the safeguarding policy and how to raise an alert in cases of abuse and neglect. Staff showed us how they accessed the policy and gave examples of the matters they would escalate.
- Trust data showed that between 87% of clinical staff had completed mandatory safeguarding adults training and 80% had completed safeguarding children level three, against a target of 85%.

Mandatory training

- 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 received electronic reminders to attend training and were given the time to attend
- However, the trust completion target was 95% and medical/dental staff completion was 55% and nursing/midwifery staff completion was 86%. Both below the planned and expected targets.

Assessing and responding to patient risk

- Early Warning Scores were completed to identify patients at risk of deterioration[DW1] .
- There was clear guidance for staff for how to escalate concerns and summon medical intervention promptly.
- Records we reviewed showed the escalation process had been follow appropriately when required
- A Venous thromboembolism (VTE) assessment was completed on each admission. There was appropriate prescribing of medication and days of administration noted. The prevention of VTE is an international patient safety issue and a clinical priority for the NHS in England.

Medical care (including older people's care)

- Risk assessments completed for each patient included falls assessment, bed rail assessment, moving and handling, Malnutrition Universal Screening Tool (MUST) and Waterlow (the Waterlow score gives an estimated risk for the development of a pressure sore in a given patient).
- Patients who were living with dementia were assessed using the screening tool used in the dementia CQUIN , Specialist assessments were also undertaken by the Mental Health Liaison Team for Older People (RAID)
- When patients were based on wards not best suited to meet their needs they were reviewed daily 7 days a week by a member of medical staff from the relevant speciality
- Records we reviewed confirmed patients were regularly reviewed.
- Although there was no critical care outreach the patient tracking system issued an automatic alert to the most appropriate clinicians when a patient became acutely unwell and secured a timely response and intervention.

Nursing staffing

- In the overall medical directorate the vacancy rate ranged from 24.9% (Rehab and enablement) to 13.2% (General and speciality medicine[DW2])
- The hospital used a nationally recognised acuity tool to determine the number and skill mix the staff required, this was reviewed twice yearly. In addition staffing levels were reviewed daily to identify nurse staffing shortfalls and as a result staff were moved between wards to distribute skill mix[DW3]
- Any additional shortfalls were covered by bank and agency staff.
- All though the ward were adequately staffed during our inspection, there was limited flexibility to cope with increased capacity and demand or short notice sickness and absence. Agency staff received an induction on the ward prior to commencing work.
- Similarly staff turnover rates varied with the highest being 67% on the escalation ward. Divisional managers worked with human resources colleagues to review exit interview information and manage staff on long term sickness leave .
- Wards displayed their expected and actual staffing levels at the entrance to wards. The head of nursing safe staffing statement 2014/15 showed that in December 2015 the average shift fill rate for nurses varied from 99% on ward E2 (Care of the Elderly) to 70.4% on the short stay older peoples ward. Similarly at night the average fill rate ranged from 100% on
- Several of the general medicine wards to 56.5% on the short stay older peoples ward.
- Medical services sickness rates between varied from 0.3% and 14%.
- In March 2015 in some instances the use of agency staff was as high as 35.9% on ward C2, 30.8% on ward A14 and 24% on ward A11
- There were ongoing local and international recruitment programs to improve nurse staffing numbers however at the time of inspection staff had not been appointed.
- Staffing levels along with mitigating actions were reviewed monthly by the quality governance committee.

Medical staffing:

- The medical wards had adequate numbers of medical staff with the appropriate mix of skills to ensure that patients received the right level of care[DW4].
- Medical services had a daily consultant led ward round system which included weekends.
- The Trust wide medical staff skill mix showed the proportion of consultants was 40%, which was higher than the England average of 39%. Junior level grade doctors were higher at 18% against the England average of 15%.
- The General Medical Council (GMC) national training scheme survey 2015 showed the trust performed within expectations, except for induction and feedback that showed worse than expected results.
- Trust data showed vacancies of 46% in gastrology and 43% in chest medicine.
- Turnover rates in medicine varied between 0% to in some areas and 40% in stroke services.
- Sickness rates also varied between 0% and 12%.
- Locum doctors were utilised to fill gaps in the medical rotas and trust data showed locum usage of 37% in general and specialty medicine and 23% in rehabilitation services.
- Senior Doctors informed us that the vacancy rates in some specialties was hampering the further development of the service and found this frustrating at times.

Major incident awareness and training:

Medical care (including older people's care)

- 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?

Good

We rated the medical services as 'Good' for being Effective because:

- Staff followed national and local guidelines and policies. The division participated in local and national audits, such as the SSNAP audit. Action plans were formulated and shared to secure required improvements .
- Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.
- Patients were assessed for pain relief and were offered appropriate analgesia.
- Staff had appraisals and access to training and development. Patient's nutrition and hydration needs were assessed and met.
- Multi-disciplinary team working worked well, Staff across the disciplines were working collaboratively to plan and provide care. Staff obtained consent to treatment and discussed care planning in a way patients could understand. Trust wide policies for mental capacity and deprivation of liberty safeguards were in place and supported by staff training.

Evidence-based care and treatment:

- Staff utilised national guidelines including National Institute for Health and Care Excellence (NICE) to deliver care and treatment. National and best practice guidelines were included in the formulation of trust policies and procedures.
- Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.

Pain relief:

- Staff were observed asking if patients required pain relief medication.
- Pain relief was assessed and managed on an individual basis and analgesia was prescribed when required.
- Patients reported getting medication regularly and when requested.

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 reported having plenty of choice at each meal and reported that the food was of a good standard.
- Fluid balance charts we inspected were accurately and appropriately maintained.
- Wards had protected meal times; however staff reported flexibility to allow relatives to help with eating and drinking as per individual need or request.

Patient outcomes:

- The heart failure audit showed the trust was below the England average for six indicators and higher than the average for prescribing beta blockers on discharge.
- The sentinel stroke national audit programme (SSNAP) audit shows the trust at Level C for April - June, there was a decrease in performance to level D from September 2014 to June 2015. However the reporting period July-September 2015 shows an improvement to Level B. There was good performance in scanning and the stroke unit throughout the reporting period.
- The heart failure audit (In- Hospital care) showed the trust was below the England average for all 4 indicators.
- The 2014-15 annual report had identified the provision of appropriate care of patients admitted with heart failure as a priority, in line with the CQIN advance in quality program targets had been set to secure continuous improvement. .A re-audit in 2014 against these targets showed there had been improvements in the standards of care.
- The myocardial infarction national audit project (MINAP) showed the trust were below the England average for all 3 non-ST segment elevation myocardial infarction indicators (nSTEMI - a type of heart attack does not benefit from immediate PCI). The 2014-15 annual report had identified the provision of appropriate care of

patients admitted with MI as a priority, in line with the advance in quality alliance targets had been set to secure continuous improvement .A re-audit in 2014 against these targets showed there had been improvements in standards of care for this group of patients. [DW1]

- The current summary hospital-level mortality rate (SHMI) for the trust was 0.943 this was in line with national expectations (July 2014 – June 2015).
- National diabetes in-patient audit (NADIA) 2013 shows the trust scored worse than the median for 14 out of 20 indicators. The trust introduced a mandatory diabetes e-learning module for staff to complete and diabetes link nurse training. An action was put in place following the audit; the plan had an identified lead and recommendations for implementation that included the development of a business case to expand the staff team.
- This was due for completion in 2015. The annual quality report 2015 had identified improvements in the service as a priority and outlined progress to date.
- In addition the diabetes task and finish group commenced in June 2014 to determine required actions to reduce patient harm in relation to the management of diabetes and insulin administration
- The trust scored in the middle 60% for 42 out of 63 questions in the cancer patient survey. 16 questions scored in the bottom 20% and 5 questions scored in the top 20[DW2]%.
- The Trust scored about the same as others for the majority of questions in the care quality commission in-patient survey, and better in one.
- The trust conducted a cannula care audit (that included medical services) between July – October 2015 and the compliance reported was between 77% - 95%.
- The trust endoscopy unit was awarded Joint Advisory Group (JAG) accreditation. This assessed the unit's policies, procedures and audit programmes to ensure best practice guidelines were met. A re-audit by JAG was set for 2016[DW3].

Competent staff:

- Appraisal rates for nursing across medical services at Stepping Hill Hospital were variable. For example figures for April 2015 to October 2015 showed an appraisal completion rate on Ward B2 (Stroke Care) varied from 95.6% in April to 78.1% in October. However the appraisal rate on A14 (Complex care) was 100%.
- Staff told us they received appraisals that were meaningful to them and supported them in their role and professional development.
- Staff reported having 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 and stroke had received training from Link nurses to their wards that enabled them to manage patient care more effectively.

Multidisciplinary working:

- Staff worked well as part of multi-disciplinary team to promote timely and appropriate discharge as well as to enhance patient recovery.
- Patient records showed joint documentation from nurses, medical staff and allied health professionals
- Communication across disciplines was well managed and each professional group valued the input of colleagues.to secure good outcomes for patients.
- Ward rounds were multidisciplinary and included medical, nursing staff and Allied Health Professionals

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Seven-day services:

- Services were available seven days per week, including access to physiotherapy.
- Medical consultant cover was 8am to 5pm on site then as on-call provision. Patients were reviewed daily on the ward seven days a week.

Access to information:

- Information boards were visible in staff areas and these displayed audit information, link nurse details and trust wide correspondence.
- Staff utilised white boards for handovers and they also included updated trust wide information as well as any issues raised locally. This included new policies, learning from new incidents and trust wide information and updates.
- Staff had access to the trust intranet and could access policies and procedures when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards:

- Staff were able to properly seek and record patient consent

Medical care (including older people's care)

- Medical staff, senior staff and therapy staff completed Mental Capacity Act assessments appropriately.
- When a patient lacked capacity staff contacted and included relevant professionals to make decisions in the patients best interests.
- Practice was supported by mental capacity and deprivation of liberty safeguards (DOLS) training with a target completion rate of 85%.
- The trust data shows that 76% of staff had received relevant training.

Are medical care services caring?

Good

We rated the medical services as 'Good' for being Caring because:

- Staff engaged positively with patients and offered kind and considerate care to them and those close to them. We saw that privacy and dignity was maintained and that 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.

Compassionate care:

- Care and treatment was delivered by caring, committed, and compassionate staff. Staff at all grades treated people with dignity and respect.
- For the NHS Friends and Family Test (FFT) the trust is similar to the England average for those who would recommend the trust between July 2014 and June 2015. However the trust response rate was 44.1% against the England average of 34.5%.
- Wards displayed FFT information on boards at the ward entrance. Wards that show good performance in the FFT scores are B2, E2 and B4 reaching 100% on multiple occasions.

Understanding and involvement of patients and those close to them:

- We spoke to patients during our inspection who reported good communication with staff and that they felt involved in care and treatment planning.
- We observed interactions between staff, patients and their relatives which were honest and open and patients and those close to them were given opportunities were given to ask questions.
- Staff gave verbal advice to patients and contact numbers were given prior to discharge if so that the patient could be offered assistance if they were anxious or worried.

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 also 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.

Are medical care services responsive?

Requires improvement

We rated the medical services as Requires Improvement for being Responsive because:

- As a result of bed pressures medical patients were often placed on surgical wards. In August 2015 there were 193 medical patients placed on surgical wards and 207 in September 2015. This meant that this group of patients were not always placed in areas best suited to their needs. In addition patients experienced a number of moves during their stay. Significant numbers of patients experienced 3 or 4 moves. This is not a positive experience for patients.

- In addition, although there was a focus on discharge planning there were a number of patients who were experiencing delayed discharge and remained in hospital longer than they needed to be. This again is not a positive experience for patients.

However we also found that:

- Services were planned to meet the needs of the local population and included national initiatives and priorities.
- There were positive good examples of initiatives to meet the needs of patients whose circumstances or illness made them vulnerable including patients who were living with dementia or who had a learning disability.
- Wards had identified dementia champions and utilised the 'forget me not' symbols so that dementia care was offered in a sensitive and person centred way
- Interpreters were available on demand for patients whose first language was not English.
- British Sign Language interpreters were also available for patients who were deaf.

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 trusts overall strategy was to focus on the care of older people so as to better met 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.

Access and flow:

- Referral to treatment (percentage within 18 weeks) shows the trusts performance above the national average between September 2014 to August 2015, apart from a small decrease to just below average in June 2015
- Data provided by the trust showed that between October 2015 and March 2016 the bed occupancy rate within the medicine business group was consistently above 90% and between January and March 2016 it peaked at 94.5%. Evidence shows that when bed occupancy rates are above 85%, they start to affect the quality of care provided to patients and the smooth running of the hospital.
- These bed pressures in the medical division meant that medical patients were often placed on wards that were outside there speciality (outliers) for example in September 2015 there were 142 medical outliers 95 of which were placed on surgical wards .
- At the time of our inspection there were two medical outlier patients had been on the clinical decisions unit (CDU) for three days. This was not in line with trust policy.
- Staff within the CDU told us that medical patients were accommodated on both the CDU and the adjacent medical assessment unit (MAU) frequently.
- Staff told us that patients would also be placed in the adjacent MAU overnight at times although senior managers did try to only use that area as a last resort. This overnight use was confirmed with a senior manager within the medicine business group.
- The standard operating procedure for the MAU stated that patients should not be accommodated overnight in the MAU and if this occurred it should be treated as an incident'. We found no reports in relation to this.
- We observed one female patient who was placed in a curtained cubicle between CDU and MAU to await a medical inpatient bed. This patient had been in the unit for over 24 hours. They did not have a locker to store their belongings and told us they were uncomfortable with men frequently passing their cubicle. They also told is it was very noisy and they struggled to sleep, we observed that the environment around the patient's bed space was very busy and noisy at times.
- However, there were good systems in place to ensure that patients were reviewed by appropriate medical staff on a daily basis.
  - As part of our inspection we found on several occasions that over 50 patients were waiting in the emergency department and admission wards for a bed in the main hospital this meant patients were not always placed in areas best suited to their needs.
- In addition patients experienced a number of moves during their stay. There were also examples of patients being moved across wards out of hours and some

patients experienced one or more moves during their stay in hospital. Between October 14 to September 15 257 patients moved more than 4 times and 632 moved more than 3 times. This is not considered a positive experience for patients.

- The hospitals capacity and flow escalation policy states that whilst adhering to specialist consultant based wards, patients should ideally not be moved more than 3 times in their complete hospital stay or during the night (after10pm) except for AMU
- Bed management meetings were held across the hospital four times a day to look at where patients were being discharged from and therefore where patients could be admitted.
- Medical patients sometimes remained in hospital longer than they needed to be. (Delayed discharges). The main reasons identified in the NHS England data from April 2013 to August 2015 for discharge delays and delayed transfers of care were patient or family choice (82.2%) waiting further NHS none acute care (9.5%) awaiting community equipment 4.6%.
- We found that there were consistently high numbers of delayed transfers of care within the medicine business group. Delayed transfers of care are defined as the number of patients who have been medically assessed as fit or discharge and are awaiting transfer of their care. In January 2016 data showed that there were high numbers of delayed transfers of care throughout the month. The average number of delayed transfers of care was 34 each day, with the highest number being 52 on one day. This means that in January on average there were 34 patients in the hospital who were deemed medically fit for discharge
- The average length of stay at Trust level for all elective and non-elective is similar to or slightly shorter than the England average.(July14 to June 2015) with the exception of none elective cardiology when the length of stay was slightly longer 8 days rather than 5.6 days
- The trust and service were working hard to try and remove barriers outside of their control to improve discharge facilitation. This included regular meetings with commissioners, the local authority and the systems resilience group. The trust was also an active partner in the Stockport together initiative which was a major transformation programme for the Stockport area. This initiative sought to bring together the health, social care and third sectors to work towards improving outcomes for patients in the local area.

.Meeting people's individual needs:

- Positive feedback was received about meeting the needs of patients with learning difficulties. Staff endeavoured to meet both the patient and carer's needs.
- Symbols on white boards behind patient's beds indicated those at risks of falls, patients living with dementia, or if assistance is required with eating. This helped staff approach and plan patients care in an informed way.
- There was a trust wide strategy for meeting the needs of patients who were living with dementia. The strategy was underpinned by staff training so that patients needs could be met in a sensitive and person centred way.
- 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..
- The trust utilised interpretation and translation services, for patients whose first language was not English.
- All inpatient admissions who 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:

- Patient advisory and liaison service (PALS) details and leaflets were available on wards and leaflets made available.
- 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 given to those wishing to forward a complaint.
- There were examples of practice improving as a result of learning from complaints.

Medical care (including older people's care)

Are medical care services well-led?

Good

We rated the medical services as 'Good' for being Well-led because:

- Staff at all levels were keen and felt supported. They were aware of the trust values and were proud of the services they provided.
- Governance and quality meetings were held regularly incidents and risks were discussed and appropriate actions agreed
- Staff felt involved in forward planning and service development.
- Local leaders were sited on the main issues within the division and were working with senior management to address these
- Staff felt supported and valued by their line managers. The trust held an annual awards event to celebrate success and achievements.
- Compliments and complaints received were shared with staff. Lessons learnt were shared and discussed in team and divisional meetings.

Vision and strategy for this service:

- 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.
- Staff were aware of the trust values and these were displayed on notice boards.
- Staff understood the vision for the trust and could show us where this was displayed on the intranet.

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 an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- Meeting minutes reviewed showed discussion of governance issues and shared action plans to secure service improvement
- Staff discussed risks that had been reported and escalated including staffing and equipment issues. The divisional risk register recorded all risks reported and the associated mitigating actions taken.
- There were regular team meetings and huddles to discuss issues and management actions .

Leadership of service:

- Staff stated that the executive team and board members were accessible and responsive .
- .Communication was effective and staff felt that they were heard and valued by the senior team.
- Staff felt well supported by their line managers .Staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared.
- Local leaders were working with senior management in the hospital to address the main challenges within the division .For example being involved in the business case presented to the board regarding the recruitment of overseas nursing staff and meeting with the Local authority and CCGs to improve patient discharge planning

Culture within the service:

- Staff were positive and felt valued by the organisation. They felt they worked well as a multi-disciplinary team and supported each other where required.
- Staff felt encouraged to raise issues and concerns and felt confident to do so.

Staff engagement:

- Staff 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.
- There were regular executive and non-executive walkabouts.

Medical care (including older people's care)

- There was an annual staff awards event to celebrate staff and team achievements.

Innovation, improvement and sustainability:

- The trust introduced the Care Certificate for health care assistants to aid development.

Patient surveys recorded via IPads enabled the trust to view results daily by clinical area.

Surgery

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

Information about the service

The surgical services at Stockport NHS foundation trust are undertaken on the Stepping Hill hospital site. The surgical services carry out a range of surgical procedures such as trauma and orthopaedics, urology, ear, nose and throat and general surgery (such as gastro-intestinal surgery). Hospital episode statistics data (July 2014 to June 2015) showed 35,825 patients were admitted for surgery at the hospital of which 58% had day case procedures, 17% had elective surgery and 25% were emergency surgical patients.

There are 10 surgical wards, a pre-operative assessment clinic and 17 operating theatres. The department carried out emergency surgery as well as day case and elective surgery procedures.

As part of the inspection, we inspected operating theatres, recovery areas, ward C3 (surgical assessment unit), ward C6 (urology) B3 and B6 (general surgery), ward D1 (orthopaedic trauma), ward D4 (spinal injuries), ward M4 (fractured neck of femur), ward D5 (day surgery), the pre-operative assessment ward and the short stay surgical unit (SSSU). At the time of our visit ward D2 (elective orthopaedics) was temporarily closed due to winter planning contingency measures. Many of the surgical services wards and departments were moving to a purpose built surgical block adjacent to the operating theatres within a few months of the inspection. This was expected to secure improvements to the environment and address some of the observations made in this report however this report reflects the environment as we found it on the date of inspection.

We spoke with 27 patients and carers and looked at 17 patient care records. We spoke with 45 staff of different grades including nurses, doctors, allied health professionals, domestics, support workers, surgeons, managers, surgical department leads, administrators and matrons. We received comments from our listening events and from people who contacted us to tell us about their experiences. We observed care and treatment, reviewed performance and assessed information about the surgery services. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

Surgery

Summary of findings

Surgery services at Stepping Hill Hospital were rated as good overall because during our visit we found services generally to be safe, effective, caring, responsive and well-led. Those patients who we spoke with who used the service felt satisfied with their care and treatment and they reported a positive experience.

There was a good culture of reporting incidents and safety issues. Investigations into incidents were thorough and there was evidence of learning and implementation of measures to improve quality and safety.

There were sufficient suitably trained staff to provide appropriate care and treatment . We found surgery services to be compliant with the World Health Organisation (WHO) checklist and National Patient Safety Agency (NPSA) 'five step to safer surgery' operating procedures. The identification of patient risk and the provision of care for the deteriorating patient were found to be good. The environment was clean and hygienic with low levels of healthcare associated infections.

Care was effective as it was planned and delivered in line with evidence based guidance and best practice. Patient outcomes were satisfactory with performance similar to other trusts and England averages. Multidisciplinary team working was good with satisfactory access to a range of specialities. Staff were experienced, competent and enthusiastic; they were knowledgeable and were supported to improve their capability. There was effective assessment of mental capacity and consent to treatment and where applicable deprivation of liberty safeguards were applied appropriately.

Staff showed kindness and compassion to their patients and protected their privacy and dignity when providing care and treatment. Patients told us staff were caring and respectful and that they were kept informed and involved in the treatment they received. This was reflected in good friends and family test results, which were better than the England average. We observed positive interactions between staff and patients and observed staff treating patient in a caring and considerate manner.

Surgical services were responsive. The hospital met the national target time of 18 weeks between referral and treatment targets overall, though they did fail to meet these for some individual specialities. There was evidence to show attention to individual patient needs and support for those with complex needs. Complaints were handled and responded to appropriately and the feedback was used to improve services for patients. Theatre utilisation was efficient which enabled better use of resources and there were no issues identified with access to treatment and flow through the service. Discharges were considered to be well organised and appropriate.

Surgical services were well-led both on a ward level and at clinical service level. Managers were enthusiastic and passionate about their service and there appeared to be a positive supportive culture throughout the surgical care group. Staff felt there was good team working and support at all levels.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- There was a good culture of reporting incidents, which were investigated thoroughly at an appropriate level with shortcomings identified and learned from.
- There was good knowledge and application of the duty of candour procedures and patients were involved in the investigations.
- Staff ensured that safe practices were followed and preventative measures were undertaken to reduce the risk of avoidable harm to patients. Such procedures were checked to ensure they were being followed.
- The wards and theatres used safety thermometer information and performance indicators to monitor their performance. They participated in national monitoring for harm free care and were rated above the England average.
- Clinical areas were clean and hygienic with effective cleaning regimes and audits.
- Staffing was sufficient to provide appropriate care and there was satisfactory provision for identifying and treating patients whose condition had deteriorated.
- Safeguarding of vulnerable patients was a priority and staff knew how to escalate and report issues of abuse and neglect.

Incidents

- Two 'never events' had occurred for the period December 2014 to December 2015. '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 healthcare providers. These incidents were a swab which was left inside a patient following an operation and a nerve block being given on the wrong shoulder prior to an operation.
- 19 serious incidents were reported between October 2014 and November 2015. 13 of these incidents were cases of healthcare related infections such as clostridium difficile; others included a fall, medication errors and the development of pressure ulcers.
- We reviewed both investigations for the never events and a sample of the investigations into the serious incidents and we found the root cause analysis (RCA) were conducted thoroughly and comprehensively by an appropriately qualified and suitably experienced investigator. Remedial actions were identified and implemented.
- We examined the procedures for incident reporting and we found that there was a good culture of incident reporting. We saw that incidents were recognised, reported and investigated thoroughly. We saw numerous examples of practical changes and learning in response to such incidents.
- The trust and the surgical services held regular Mortality and Morbidity meetings; all deaths relating to surgery were scrutinised by a senior surgeon and any learning outcomes were discussed and circulated.
- We saw examples of the 'duty of candour' being implemented appropriately following harm caused to a patient. The duty of candour is a regulation introduced for all NHS bodies in November 2014; it encourages hospitals to act in an open and transparent way when things go wrong and sets out what a hospital must do if harm has been caused to a patient. We found the process was in line with trust policy and national guidance. Patients were involved at an early stage following incidents and were offered the chance to speak with senior staff.

Safety thermometer

- The NHS Safety Thermometer is an assessment tool which measures a snapshot of harms once during the month (such as falls, pressure ulcers, bloods clots, and catheter related urinary infections).
- Information relating to safety thermometer results was clearly displayed and visible in the wards and theatre areas.
- We found that surgical services used the safety thermometer and dashboard information to monitor their own performance, identify areas they can improve and benchmark themselves against other wards and departments.
- Information provided to Health and Social Care Information Centre showed that from January to December 2015 the trust reported 95.4% harm free care, this is better than the England average of 93.7%.

- Surgical services reported 14 cases of clostridium difficile and one case of methicillin resistant staphylococcus aureus (MRSA) from December 2014 to November 2015.
- Nine pressure ulcers and three catheter related urinary tract infections were reported between December 2014 and December 2015.
- The trust reported 110 cases of venous thromboembolism (VTE) for the period January 2015 to December 2015. This represents 0.54% of patients cared for, which was slightly higher than the England average of 0.41%. Six surgical patients developed VTEs during this period.
- Surgical services reported no falls with harm from December 2014 to December 2015, however we were notified of two falls which caused serious injury in January 2016, investigation into those cares was still ongoing.

Cleanliness, infection control and hygiene

- We found the environment to be visibly clean and hygienic and that there was effective cleaning audit regimes in place.
- We observed staff following hand hygiene procedures and 'bare below the elbow' guidance. We saw staff using appropriate protective personal equipment, such as gloves and aprons, when delivering care.
- Infection control protocols and gowning procedures were adhered to in the operating theatre areas.
- The trust had an infection control team with infection control specialist nurses who were available to staff for training, advice and consultation.
- Surgical services reported one MRSA infection and 14 clostridium difficile infections for the period December 2014 to November 2015. The reported infection rates for the trust were similar to rates reported nationally during this period.
- We found that some wards in the old part of the hospital notably ward C3 (surgical assessment unit) and C6 (male general surgery) were not ideal for effective isolation procedures. Single rooms which accommodated patients with suspected or confirmed infections did not have ensuite facilities, and did not comply with best practice relating to isolation procedures. This issue would be resolved as the ward was to be moved into the new surgery block accommodation which would provide purpose built isolation facilities.
- Surgical services showed evidence of compliance with trust policies including those relating to hand hygiene, use of personal protective equipment and waste management.
- The managers undertook regular audits into infection control to monitor compliance and identify areas for improvement.
- Audits from November 2014 to October 2015 showed compliance with hand hygiene was 96.3%, for compliance with cannula care 98.7% and compliance with catheter care was 97.9%.
- Surgical services undertook surgical sight infections surveillance of 74 hip operations performed during 2014/2015 and identified no incidents of surgical sight infections during that exercise.
- We reviewed an investigation and action plan for a clostridium difficile infection that occurred in November 2015. This showed that the incident had been appropriately investigated and with input from infection prevention specialist nurses and other relevant staff.

Environment and equipment

- Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs and confirmed any faulty equipment was either repaired or replaced promptly.
- We saw that an equipment PAT testing and maintenance regime was in place and stickers showed checks were up to date.
- Overall we found that the ward and theatre areas were well maintained, free from clutter and provided a suitable environment for treating patients. However, on ward M4 (fractured neck of femur) we saw that hoists were stored along the corridor. Staff explained that there were issues storing the equipment due to the design and layout of the ward.
- Waste and clinical specimens were handled and disposed of in a way that kept people safe. This included safe sorting, storage, labelling and handling.
- Other equipment such as commodes and hoists were seen to be clean and well maintained. When items were used they were cleaned and labelled as clean in line with Trust policy. However on one ward, dates on some equipment were some days earlier, one shower chair was recorded as being cleaned on 23.12.15, indicating it had not been cleaned for 4 weeks. This was pointed out to the manager who responded quickly to the matter and ensured the items were cleaned.

- We reviewed all resuscitation equipment across surgical services we found that defibrillators were not standardised across surgical wards, during our inspection we saw three different types of defibrillators in use, this is contrary to resuscitation UK best practice.
- The trust was transitioning from daily to weekly checks on arrest trolleys and we found that there was inconsistency in application of the new policy, some areas were still checking daily and others were checking weekly. However we were satisfied that they were being checked and maintained in line with trust procedures.
- We noted that although arrest trolleys were being checked and sealed, all but two surgical wards were not keeping a record of that seal number. This meant it was not possible to determine if the equipment had been tampered with and a new seal applied. This was highlighted to the managers who reacted swiftly to rectify this issue. The following day we observed that a new system had been introduced to record seal numbers.
- In theatres, there was an arrest trolley which was not sealed and which contained medications, this was against trust policy and was highlighted to managers.
- The trust used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable surgical instruments. There was sufficient storage space in the theatres and items such as surgical procedure packs were appropriately stored in a tidy and well organised manner.
- On ward C3 (surgical assessment unit) we saw that storeroom 1 was left open, this was used for storing items such as intravenous giving sets, oxygen masks and instillagel medication. This presented an opportunity for items to be tampered with, which could pose a risk to patients.
- Bariatric equipment was available to the wards and theatres if required.

Medicines

- We found that overall medicines, including controlled drugs and intravenous (IV) fluids were stored safely and in line with agreed protocols.
- However, on two wards we observed that some IV medications such as antibiotics and IV paracetamol were not in a locked in a medicines cabinet. They were stored in unlocked drawers within a locked room. Whilst this is consistent with Trust Policy, it appears inconsistent with The Royal Pharmaceutical Society of Great Britain (RPSGB) guidance 'The Safe and Secure Handling of Medicines' (2005).
- We observed records that showed that staff carried out daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. During the inspection we also checked a random selection of controlled drugs on each ward and department and found the stock balances correlated with the registers. We also saw that the controlled drugs book showed evidence that two staff members had signed for controlled drugs.
- However, in theatres we found that policy was not being adhered to regarding the disposal and 'wasting' of controlled drugs, where the full contents of a vial was not prescribed. We also found that medications were stored on an unlocked arrest trolley in the recovery area.
- We found that medicines requiring cool storage were stored appropriately and records showed that refrigerators were checked daily to ensure they were at the correct temperature.
- A ward pharmacist was available daily Monday to Friday and via an on call system at weekends, we saw that the pharmacist reviewed prescriptions and patients' medicines admission medicines and that records were correct up to date and medicines were available.
- Patients' drug allergies were clearly recorded on notes, above their bed space and such patients wore a red wristband to highlight this.
- Two wards used patient group directive (PGD) prescription arrangements for common medicine administration, however following the change from written to electronic prescribing, there seems to be some uncertainty over the process. During our visit, we asked to see a list of those who were trained, named and authorised on the PGD, but this could not be produced.

Records

- As part of our inspection, we reviewed the records of 17 patients and found these to be accurate, complete, legible and up to date.
- The records contained the relevant patient history, patient allergy status, relevant information and applicable risk assessments. We saw care plans and pathways were completed thoroughly in nursing notes.

- We saw that there was a good system for pre-operative assessments, which had a thorough and comprehensive system to assess and highlight individual patient needs. They also initiated some integrated care pathways for some procedures.
- We noted that patient records and documentation, particularly on wards were not locked away. Patients' records were kept in trolleys which were located in areas staff were usually located, such as nurses stations and staff rooms, however there was no guarantee that these were monitored at all times.
- We looked at the patient track electronic system for recording patient vital signs and observations and how assisted with monitoring patients and use of the early warning system.

Safeguarding

- All staff were aware of their responsibilities regarding safeguarding and the correct procedures to follow; they could describe how to access the policy on the trust intranet and who to speak to for advice.
- Staff received training and annual updates, the level of which was dependent on their roles.
- The hospital had specialist safeguarding nurses who were available for Monday to Friday for advice and information. Outside of those hours, the hospital coordinator was available for assistance.
- We witnessed that the procedures were being used effectively and saw evidence of a multidisciplinary team meeting to discuss the best interests and safety of a patient.

Mandatory training

- Mandatory training was updated by attendance on training courses or by training done remotely on a computer. The subjects classed as mandatory are those which are considered the most important such as basic life support, safeguarding patients and moving and handling.
- Compliance with mandatory training was 83.6% against an accepted target of 95%; this was the record of compliance for the surgical and critical care services as a whole. When we looked at individual ward and department records, we saw that ward managers kept a check on the training their own staff required and arranged for them to complete it. Ward mangers told us they were mostly up to date and that statistics had been affected by inclusion of persons who no longer worked there or who were on long term sick. However this could not be supported by records provided by the trust.

Assessing and responding to patient risk

- Patients were assessed for risk prior to surgery through history taking, tests and examination. Comorbid conditions, past medical history and lifestyle issues were captured appropriately and used to establish an ASA class as per best practice. This was recorded at pre-operative assessment clinics where possible and upon admission for procedures that were not pre-planned.
- Surgical services effectively used the early warning system (EWS) to identify sick and deteriorating patients who required closer attention. They used an electronic patient track system to record observations and vital signs. These could be accessed remotely to manage demands and plan for service delivery. The critical care unit monitored patients remotely to plan for potential level two and three care provision.
- Sick patients whose EWS scores reached 'trigger points' were reviewed by doctors on a time scale that was dependent on their score. In an emergency situation, a rapid response team who held emergency 'bleeps' attended to treat the patient quickly. During our visit, we witnessed one such emergency, all relevant and qualified staff attended and stabilised the patient who was then taken to theatre for treatment. The system was organised, calm and effective.
- We observed the operating theatres to be compliant with the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist by witnessing the processes during our inspection. Theatre managers regularly review compliance through an audit process and act on any shortcomings found, we reviewed the audits and were satisfied that a robust process was in place.
- A 24 hour telephone number was provided to patients upon discharge from the day and short stay wards, this gave advice on what to do and who to contact if concerned following discharge.

Nursing staffing

Surgery

- Staffing figures show that the trust is running at around 90% of establishment of nurses, this acceptable in terms of the National Institute of Clinical Excellence (NICE) safe staffing guidance.
- Staffing establishment had been reviewed using a nursing acuity tool, which had increased the establishment of nurses on many surgical wards. This was compliance with NICE recommendations that registered nurse should have responsibility for no more eight patients.
- Surgery services had negotiated a difficult period with 26 (whole time equivalent) unfilled registered nurse vacancies and high rates of sickness and maternity leave; however they had successfully recruited to their vacancies and some of those had just started working, with others to follow over the next few weeks.
- Ward managers told us they filled staffing shortfalls with staff overtime, managers being included in the numbers and some use of agency staff. They could also notify shortages to the hospital co-ordinator who could move staff from other wards. We were assured that only surgical trained nurses would be used on surgical wards., We saw this process in practice; a trained surgical nurse was moved from ward B3 to M4 to cover staff shortages.
- Each ward we visited displayed expected and actual staffing levels which were updated on a daily basis.
- Agency staff received an induction upon arrival on a ward,. We observed an agency nurse on induction and were satisfied this was sufficient to enable them to practice safely.
- The trust spend on agency nurses 3.4% of the total nursing spend which has reduced significantly from 6.9%.
- Nursing staff sickness is high in places; this was around 6% on five of the 11 areas we visited. The others areas recorded rates around 3% which was lower than the 4% average rate for this staff group.
- Skill mix was good; many staff we spoke with had been working for the trust for a number of years. They were enthusiastic and competent in their field. On the short stay surgical unit and day surgery ward they undertook nurse led discharges which required additional skills. When these staff were sick or staffing was short it was difficult to find suitably trained staff, however, due to a good relationship between wards and staff flexibility this had been managed.

Surgical staffing

- The surgical wards and theatres had adequate numbers of surgical staff with the appropriate mix of skills to ensure that patients were safe and received the right level of care.
- Surgical services had a daily consultant led ward round system. During weekends a consultant would review new patients and those patients who were most critically ill. Other patients who may not have been seen by consultant were reviewed by a surgical registrar. Where there was not a consultant physically on site, such as evenings and weekends they were readily accessible by telephone for advice and support.
- Consultants operated an on-call system, so there was always 24 hour consultant availability, during their on-call duty they were free from other clinical duties to ensure they were available if needed.
- Surgical handovers were undertaken at shift change to ensure that incoming doctors were made aware of patients and their particular needs.
- Junior doctors told us they felt supported by their consultant and they always had access to the advice and support they required.
- We found there was some use of locum doctors, these locums were generally block booked and received an adequate induction process prior to practicing, to ensure they were able to care for patients appropriately in the new environment.

Major incident awareness and training

- There was a documented emergency preparedness and business continuity management policy and strategy for dealing with major incidents and emergencies such as terrorist threats, flood, fire or process management failures.
- The surgical and critical care business group has completed a business impact analysis report as part of their input into the trust's major incident plan.
- All staff received emergency planning training on their corporate induction training days.
- Fire and bomb training was updated annually as part of the mandatory training package.
- Emergency evacuation tests were conducted periodically.

Surgery

- Protocols were in place to defer elective surgical activity in order to prioritise unscheduled emergency procedures. There is also a seven day, 24 hour emergency theatre in operation under the CEPOD arrangements.

Are surgery services effective?

Good

Care was provided in line with national guidance and best practice. The service provided emergency surgery 24 hours a day, seven days and week. They utilised their theatre time effectively to treat as many patients as possible. Patients were assessed for their pain and nutritional requirements and they were treated effectively.

Services were provided by competent staff who worked as part of a multidisciplinary team to meet the holistic needs of patients. Staff ensured that patients had the understanding and ability to consent to their procedures and where this could not be achieved, the best interests of the patient were considered. Staff had access to the right information to enable them to carry out care and treatment in a timely and professional manner.

Evidence-based care and treatment

- Surgical services used national guidelines and best practice to care for and treat surgical patients. They monitored their compliance through audits and benchmarked their performance against local and national standards.
- Emergency surgery was managed in accordance with the national confidential enquiries into patient outcome and death (NCEPOD) recommendations and the Royal College of Surgeons (RCS) standards for emergency surgery.
- Services complied with local policies and procedures and followed established integrated care pathways for individual procedures. Some of these pathways were initiated at pre-op clinic.
- Relevant National Institute for Health and Care Excellence (NICE) guidelines were followed including 'recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'rehabilitation after critical illness' (NICE clinical guideline G83).
- Care pathways followed relevant guidance including hip fracture, surgical site infection, and VTE best practice.
- Occupational and physiotherapists held pre-operative educational sessions with patients in order to help them be as fit as possible for surgery; they spoke about exercise, diet and medication.
- Specialist staff were available to provide advice and assistance to surgical patients regarding lifestyle choices such as smoking and alcohol cessation. The pre-operative assessment unit recorded the greatest number of referrals to the service across the hospital.
- Enhanced recovery pathways were in place for a number of procedures. Enhanced recovery was an evidence-based approach to care which has been shown to help patients recover more quickly after surgery.
- There was no evidence that patients were discriminated against on the basis of their individual differences or membership of a particular group.

Pain relief

- Surgical services had access to a dedicated pain team with specialist pain control nurses from Monday to Friday. During evenings and weekends pain advice could be sought from the on-call anaesthetist another pain control specialist.
- Anticipated pain issues were assessed and noted at the pre op assessment, such patients were referred to the anaesthetist and pain team for their specialist input prior to surgery.
- Inpatients had their pain assessed regularly; this was recorded on and was integral to the patient track and early warning system. This helped ensure a systematic approach to pain assessment to promote effective pain management.
- However one of the patient records we checked indicated a delay in the administration of analgesia for one patient, this was highlighted to the ward manager who accepted it was an oversight. Also one of the patients on a different surgical ward stated that she had experienced a delay with her pain medication, though she was happy with her overall care and treatment.

Nutrition and hydration

- Patient records included appropriate assessment nutritional requirements and those on fluid and food charts were updated regularly.

- Wards had access to a dietician who provided advice and input for those people who were highlighted to be at risk of dehydration or malnutrition.
- Patients are routinely prescribed and given medication to prevent and treat nausea following surgery.
- On one ward we observed a good system for highlighting the nutritional requirements of individual patients. They used a system which easily identified patients on fluid, food charts, those who needed assistance or encouragement with eating and drinking.
- Surgical wards had access to a diabetes specialist nurse who could offer advice to patients and staff. Diabetic patients were allocated first slot on theatre lists where possible and were monitored closely prior to and following surgery.
- Patients told us they were happy with the quality and choice of food and that was provided.
- A patient who needed help with eating and drinking told us that the staff assisted her at meal times and throughout the day.

Patient outcomes

- Surgical services undertook 35,000 procedures last year, 25% were emergency surgery cases, 58% were day cases and 17% were elective surgery cases.
- Surgical services completed various national audits such as the hip fracture, bowel cancer and emergency laparotomy audits and they completed performance indicator data to review their service provision. They identified any shortcomings and took steps to try to improve outcomes where possible. As part of our inspection we reviewed various action plans and initiatives to improve performance and outcomes, we saw that these were reviewed and acted upon to measure any impact.
- The hip fracture audit (2015) showed the trust performed better than the national average in five indicators and worse in four indicators. They were significantly better admitting patients into orthopaedic care within four hours and more patients received their operation on the same or day following admittance than the national average. However patients had longer hospital stays and received less specialist geriatrician input than elsewhere in England.
- The bower cancer audit (2014) showed the trust performed better than the England average for case ascertainment rate, data completeness, multidisciplinary team discussions and having a CT scan, but performed worse for clinical nurse specialist input and more patients stayed in hospital longer than 5 days than they did on average across England (77% at Stepping Hill; England average 69%).
- The emergency laparotomy audit (2015) showed mixed results, Stepping Hill achieved moderate adherence with most key processes of care, however they achieved consultant surgical review of patients within 12 hours of an emergency admission in less than 50% of patients.
- The standardised relative readmission risk for surgical patients at Stepping Hill was higher than the England average for both elective and non-elective procedures in general surgery and urology and for elective trauma and orthopaedic procedures, but the risk of readmission following non-elective trauma and orthopaedic procedures was lower than the England average.
- Performance reported outcomes measures (PROMs) data between April 2014 and March 2015 showed the percentage of patients that had improved following groin hernia, hip replacement and knee replacement procedures was either similar to or better than the England average.
- Trust data showed that the operating theatres at Stepping Hill were utilised effectively with 75% utilisation overall (this did not include the two emergency theatres data).

Competent staff

- Newly appointed staff received an induction into the trust and had completed competency assessments before being allowed to work unsupervised.
- Staff who had made a medicine error were given extra training and supervision for medicines administration.
- Appraisals were conducted annually with managers to review and feedback performance and development issues with individual staff. Trust data showed that 80% of the surgery and critical care staff group had received their annual appraisal as of December 2015. The trust had introduced initiatives to improve this, one aspect being that no new external training would be approved unless all that member of staff's appraisal and mandatory training had been completed.
- The appraisal rate for medical staff was 96% as of December 2015.
- The trusts had signed up to the new care certificate for non-registered staff and all new support workers in the

trust have achieved the certificate and others were working towards it. This has proved popular amongst support workers who were positive about its implementation.
- Staff told us they were happy with the development opportunities that were available and felt they were supported by managers to pursue their own interest where this was related to the needs of the department.
- Junior doctors told us the work was interesting and challenging and gave them the opportunity to develop their surgical skills and experience in a supportive environment. They received two teaching sessions per week which they found beneficial in their development.
- Surgical services used advanced nurse practitioners, nurse clinicians and non-medical prescribers to supplement the work of doctors in the care and treatment of patients. Those nurses felt supported in those roles and were happy with the opportunities to develop their skills.
- Theatres multidisciplinary team have received 'human factors' training following the incidents in theatre which the team improved team competence.
- Advanced nurse practitioners and practice educational staff were on hand to offer support and improve competency through teaching and educational sessions.

Multidisciplinary working

- Surgical services operated good multidisciplinary working. The care and treatment of patients was co-ordinated between different teams and departments such as theatres and wards and the departments communicated well between them.
- Occupational and physiotherapists worked with patients to assist in their recovery and rehabilitation particularly on the orthopaedic wards. They were involved in the pre-operative care of the patient by providing education sessions in order to prepare the patients prior to and following their surgery.
- Pharmacists were available on a daily basis and operated out of hours cover during the weekend.
- There was access to a wide range of specialist staff such as stoma care, palliative care, tissue viability specialists, which could be requested for advice and input.
- Orthopaedic wards such as M4 (fractured neck of femur) and D2 (orthopaedic trauma) worked collaboratively with social services and local authority staff to organise ongoing and community care for patients being discharged.
- Surgical services worked with rapid assessment interface and discharge (RAID) staff who were based at the hospital, they worked together to manage the needs of patients living with dementia and mental health problems upon admission and when planning discharge.
- Staff reported that the multidisciplinary team relationship was good and the team worked well together. Staff we spoke to from a range of specialisms and grades said they felt like part of a team and felt supported and involved in patients' care and treatment.

Seven-day services

- All patients were reviewed by a surgeon daily, consultants undertook weekend ward rounds but did not always see every patient, they may just see the new and sickest patients. Those not seen by the consultant would be reviewed by a surgical registrar.
- There was a 24 hour, seven days a week NCEPOD emergency operating theatre, which provided treatment for patients that required emergency surgery. If a further theatre was required theatre staff were on call to staff a further theatre.
- There was access to laboratories and pathology out of ours and at weekends, turnaround was good and no problems were identified.
- There was access to pharmacy via an on call system out of ours and at weekends.
- Magnetic resonance imaging (MRI) scans were available through an agreement with Salford Royal NHS Trust during the weekend.
- Computerised tomography (CT) scans were available on site during the weekend; but were reviewed and reported on by an external radiographer. We heard mixed views on the standard of the reporting during this period; however a trust radiographer was on call if further assistance or discussion was required.
- Occupational and physiotherapists were available at the weekend, but it was recognised that this service could be better and work was being done to improve weekend access.

Access to information

- Physical notes and electronic patient records were kept up to date, were accessible and were easy to follow.
- However, it was difficult to follow a patient's prescription documentation for those who were admitted through accident and emergency as the departments used different prescription charts. We noted a previous serious incident had occurred which identified this as a contributing factor and we again noted that this was a contributing factor to the delay in pain relief identified earlier in this report.
- Records contained all relevant detailed patient information including surgical procedure to discharge planning.
- Important information such as safety alerts, audit results and performance information was displayed in staff areas to help keep staff up to date and aware of issues.
- Staff had access to trust and external information including policies and procedures from the trust's intranet.
- Wards had a large screen which provided clear individual patient information at a glance such as EWS scores and patients with elevated risk of harm. This patient track information could be viewed remotely, which assisted with the monitoring and reviewing of patients and the management of patient dependency.
- The theatre department used the 'operating room management information system' (ORMIS), which advised them on the progress and status of each theatre and procedure, including those cases completed and those waiting to be treated. This was an effective tool which kept the theatres running efficiently and effectively.
- Surgery services had good access to patient's physical records which were stored on site. Some patients from other areas also had treatment at Stepping Hill and a system was in operation to have these couriered over. It was very unusual that patient notes could not be obtained and staff could not recall an occasion when this happened.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgical staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff recognised the importance of informed verbal and written consent before providing care or treatment and took steps to ensure it was within the patient's capacity to consent.
- Mandatory training regarding the mental capacity act was provided however the uptake of this training was below the trusts target for both the nursing and medical staff groups within the department. 82% of nursing and medical staff had undertaken this training. Training in this area is particularly important as patients often present to the service with an altered consciousness and it is important that nursing and medical staff are trained and able to assess their mental capacity and understand patients' rights in relation to mental capacity and self-determination.
- Staff recorded assessments of capacity in patients' records and undertook routine dementia screening of patients over 70 years of age.
- Where a patient lacked capacity to make a decision, decisions about care and treatment were made by relevant professionals within a multidisciplinary team setting. Input was sought from the patient, their family and their representatives. Such decisions were made in the best interests of the patient and were documented and recorded appropriately.
- Staff were familiar with the Mental Capacity Act (2005) and the deprivation of liberty safeguards (DOLs). They showed good insight and identification of those whose liberty may be impacted and took steps to ensure these were highlighted. During our visit we reviewed three DOLs authorisations and we were satisfied that the correct procedures had been followed.
- A trust safeguarding team provided advice and guidance on these matters for staff, patients and their representatives.

Are surgery services caring?

Good

During our inspection we spoke with 27 patients and carers. The patients and carers we spoke with were positive about the care and treatment experienced. They felt they were listened to, had time to have their questions and concerns addressed and they felt that both patients and their relatives were included and involved in decisions

about their care. They also told us staff were caring and respectful and demonstrated kindness and compassion towards them. This was reflected in good friends and family test results, which were better than the England average.

We observed positive interactions between staff and patients and observed staff treating patients in a caring and considerate manner and we saw that staff ensured they protected the privacy and dignity of patients when providing care and treatment. We saw that there was emotional and practical support for patients from a range of services.

Compassionate care

- The NHS friends and family test (FFT) is a survey which asks patients whether they would recommend the NHS service they have used to their friends and family. The FFT results for November 2015 showed that 94% of patients would recommend surgical services. The response rate for the survey was 47% which was much higher than the England average.
- The patients we talked with spoke very highly of staff and felt they had been treated with dignity and respect.
- Throughout our inspection, we witnessed positive and caring interactions between staff and patients. We saw that staff introduced themselves and asked patients permission before carrying out care.
- Cubicle curtains and doors were closed during consultations and patient care and staff sought permission before entering such areas.
- Results from the patient-led assessments of the care environment (PLACE) showed that the trust achieved mixed results in 2015; they were rated slightly worse than the national average for cleanliness, privacy and dignity, building maintenance but better for food provision.

Understanding and involvement of patients and those close to them

- The patients and relatives we spoke to told us they felt members of staff were respectful and listened to what they had to say. Patients said they felt they had sufficient time to ask questions and have their questions answered.
- Patients said they received clear information about their care in a way they understood which enabled them to make informed choices about treatment options. This is supported by what we saw during our visit.
- Patient and relatives told us they felt included in the decision making process and could contribute to planning and delivery of their care and treatment.
- We saw that staff acted upon the individual preferences that were expresses to them and communicated these sensitively to other departments in the patient's journey. Records were updated to include individual preferences.

Emotional support

- During our visit, we observed emotional support being provided by staff of all grades, who spoke with patients and relatives in a comforting and supportive way.
- Stockport NHS offered a carer and family bereavement service which offered support for relatives of those who had passed away at the hospital. This included a counselling service together with practical help and advice. They also produced useful advice leaflets.
- The trust also provided a range condition specific emotional support through the expertise of nurses specialising in cancer, cardiac, heart failure, diabetes, colorectal and stoma, pain, safeguarding and palliative care.
- Assessments for those that may need greater emotional support, such as those with phobias, mental health problems or anxiety were conducted at pre-operative clinic. Any identified need which may impact on care was highlighted and where necessary referred for a reasonable adjustments meeting.
- The chaplaincy and spiritual service was also available for spiritual, religious or pastoral support to those of all faiths and beliefs.

Are surgery services responsive?

Good

Patients were provided with care and treatment in a timely way and the needs of local people were considered in the planning and delivery of services. Surgical services were meeting the NHS England targets that 92 per cent of patients should receive their treatment within 18 weeks of being referred. The numbers of cancellations of operations were low and the majority of those patients had their operations rescheduled and performed within 28 days.

Surgery

The individual needs of patients were taken into account including those living with dementia and learning difficulties and furthermore staff made reasonable adjustments to encourage and enable vulnerable people to access the service.

Stepping Hill had a good system for seeking feedback from customers and acted upon complains and comments received, making improvements where they found inadequacies.

Service planning and delivery to meet the needs of local people

- Surgical services provided pre-planned day surgery, emergency and elective trauma and orthopaedic, urology, ENT, oral and general surgery services on site at Stepping Hill. The local population could receive surgery in other specialities such as cardiac, vascular and plastic surgery through arrangements with neighbouring trusts.
- They had 17 operating theatres, one of these was a NCEPOD emergency theatre which was staffed 24 hours a day, seven day a week, to provide facilities for patients who required urgent surgery, this enabled access to prompt treatment out of hours and weekends.
- There was adequate bed spaces in the theatres block to ensure patients could be appropriately cared for pre and post-operation. The department operated a red, amber, green (RAG) escalation protocol to highlight if there were issues with the flow of patients, which enabled them to respond to bottlenecks or delays in the flow of patients.
- Some wards in the old part of the hospital particularly ward C3 (surgical assessment unit) provided a difficult environment for patients and staff. Patients who waiting for treatment and review said the waiting areas were uncomfortable and afforded them no privacy. We saw that the environment was not suitable, the area was cramped and small and there was no drinks machine or television facilities. The department was aware of these issues and anticipated that the move to the new surgical block would alleviate these issues as it had been designed for this purpose.
- The areas we inspected were compliant with same-sex accommodation guidelines, we observed that males were cared for in separate areas to females.
- Results from the Care Quality inpatient survey showed that the trust as whole performed similar to other trusts in all areas of the survey.

Access and flow

- Patients were admitted to surgical services through a number of routes; through the accident and emergency department (A&E), through GP referral directly to the surgical assessment unit (SAU) or were admitted for pre-planned or elective surgery as an inpatient or day case patient.
- Bed occupancy figures provided to NHS England show bed occupancy rates from July 2015 to September 2015 were 83%. This is lower than the England average of 87%.
- NHS England recommend that patients should see a specialist with 18 weeks of being referred and that trusts should aim to achieve this for at least 90% of patients. Overall Stepping Hill attained 92% referral to treatment times (RTTs), however some individually specialities did not. In December 2015, general surgery achieved 86.4%, ear, nose and throat surgery achieved 85.9% and oral surgery achieved 90.4%.
- For a period of about a month in December 2015 to January 2016, surgical services cancelled all elective orthopaedic operations for strategic reasons. They filled the theatre slots by increasing day and short stay operations. However, it is noted that suspending those procedures would subsequently impact on the future months RTTs.
- From July to December 2015, surgical services cancelled 173 operations at short notice and for non-clinical reasons. The main reasons for these were running out of theatre time, lack of available staff, lack of available beds, urgent case took priority and equipment failure or shortage. When a patients operation was cancelled at short notice for non-clinical reasons, they should be offered another appointment within 28 days, for those patients cancelled only three were not treated within 28 days. This was better than the England average.
- Surgical services had a good system for booking appointments, both for pre-operative assessment clinic and for admission. There was flexibility in arranging appointments which meant patients could access treatment at a time that suited them.
- Some patients who had been referred to surgery during outpatient appointments were immediately sent to the pre-operative clinic to have their assessments

completed. The clinic had pre-planned vacant appointments for such patients which prevented a return visit to the hospital and facilitated timely access to treatment.

- The Ward D5 (day surgery) and the short stay surgical unit (SSSU) operated a nurse led discharge process. Nurse clinicians were trained to assess patients' fitness for discharge. If they had any reservations they could refer to surgeons for further input.
- Upon discharge patients GPs were sent a summary of the treatment their patient had received, these were computer generated documents, many of which were transmitted directly to the GP surgery, a copy was also given to the patient.
- Trust data shows that 86.9% (against a target of 95%) of discharge letters were completed within 48 hours of a patient's discharge for October 2015 to December 2015. This had improved from 77.8% for the same period in 2014 and the trust were continuing work to improve this further.
- Figures from January 2015 to December 2015 show that around 57% of discharges occurred before 4.30pm. This enabling better coordination with services and ongoing care in the community. 17% of patients were discharge during the weekend period.
- Patients were given discharge booklets and information about care following their procedure. They were also given details of who to contact if they had concerns in the days following their discharge.
- Surgical services had some patients who were medically fit for discharge who remained in hospital due to difficulties in community care and rehabilitation. Complex discharges were handled by social workers, discharge planning staff and the multidisciplinary hospital and community teams.
- The care of a patient on a ward that was not best suited to their needs such as surgical services patients who were care for on medical wards were classed as 'outliers'. Throughout our inspection, we found there were few surgical outliers; however we were satisfied that where this did occur those patients were managed effectively. Surgical doctors told us they were made aware of any surgical outlier patients and they would ensure that they were reviewed daily on ward rounds and were moved to surgical areas as soon as possible.
- The British Orthopaedic Association 'standards for trauma' (BOAST) recommend that patients with a fractured neck of femur should have reparative surgery within 36 hours of presentation, they state that delays in treatment are associated with increases in mortality and morbidity for such patients. From July 2015 to December 2015 78% (162 out of 211 patients), were treated within the recommended time.
- In the six months August 2015 to January 2016, 3.27% of patients failed to attend for their operations, this rate was lower than the England average.

Meeting people's individual needs

- Surgical services had a good system for identifying patients with complex needs particularly those that entered the service through the pre-operative assessment unit. We saw evidence that needs were highlighted and there was forward planning for those living with dementia, learning difficulties and mental health problems.
- The trust has a learning disabilities liaison support nurse who can provide assistance to those with learning difficulties on their admission and during their stay in hospital.
- Surgical services had a good system for pre-operative assessments, the process was thorough and clear. It was at this stage that some integrated care pathways were commenced.
- Patients over 70 were screened for dementia upon admission; however there was some uncertainty over this procedure with staff we spoke with. One of the patient records we reviewed was for a patient over 70; however a dementia screening had not been completed.
- If a patient was identified to have individual needs, they were allocated a side room were where possible, but this was not always possible due to the nature and construction of the old hospital buildings as there was a shortage of side rooms for single occupancy; it was believed that this shortage would be relieved by the move into the new surgery block.
- Relatives and caregivers of those patients with complex or additional needs would be allowed to stay with the patient if required.
- Wards had dementia champions who had received extra training on dementia.
- Over winter, the hospital undertook a 'knit a mitt' campaign for patients with dementia, this recruited members of the public, staff and patients to make activity mitt for inpatients living with dementia to help keep them calm and occupied during their stay. Parts of

the environment on many wards was not dementia friendly, it was not consistent with current best practice and recommendations regarding the use of images, colour, height and size of signage and the use of colour within the environment and patient bathrooms. It is believed that some of these issues will be improved with the move to the new surgical block.

- Stepping Hill hosted a transgender equality event in September 2015 to increase awareness about transgender issues.
- Surgery services produced a wealth of leaflets and condition or procedure specific information. They were in English, but on the reverse there was information on how to obtain these in other languages, written in those languages and script.
- All leaflets could be provided in different languages or formats such as braille, large print and easy read if requested.
- The Trust had 24 hour access to an interpreting service and could provide interpreters and translators if notified in advance. They could also arrange lip reading and sign language services for those who required them. They had fixed and portable induction loops for those who used hearing aids.
- Rapid assessment interface and discharge staff (RAID), who were specialised in dementia or other mental health problems worked with ward staff to provide assessments and advice, this enabled better identification of the needs of patients so their individual needs could be accommodated.

Learning from complaints and concerns

- Patients knew how to complain and raise concerns, there was information on noticeboards and a 'complaints, comments and concerns' patient leaflet was available around the hospital which provided information on how to complain.
- The leaflet was clear and simple, it provided a space where the complaint could be written, and it also gave advice on advocacy services and the parliamentary ombudsman.
- Complaints, comments and concerns were submitted to the patient and customer services (PCS) department who handled the feedback.
- The trust recorded a system of formal and informal complaints. Generally informal complaints were where patients had raised an issue or expressed dissatisfaction verbally and formal complaints were those written and submitted formally.
- Complaints were monitored centrally and were referred to the managers in the relevant business group investigate and respond to. Complaints were allocated a deadline depending on their complexity and seriousness and were to be resolved within 25, 35 or 45 days.
- Each complaint had a 'complaints resolution plan' which was added onto the datix incident reporting system.
- All complaints were reported in the quarterly complaints report and reviewed by the quality governance committee. Complaints trends and themes were analysed and reported in the annual complaints report.
- Surgery services received 91 formal complaints between December 2014 and November 2015; this represented 12% of all complaints received. The main reasons for complaints were dissatisfaction with treatment, attitude of staff, communication and delays or cancellation of appointments.
- During our visit, we saw evidence that wards do act on complaints and take action to make changes to improve patients' experience. Learning from complaints were discussed at team meetings, safety huddles and circulated in newsletters. For safety and serious concerns staff were made to sign to say they have read and understand the feedback.
- There was a patient advice and liaison service (PALS) at Stepping Hill hospital which provided a range of advice for patients and relatives.

Are surgery services well-led?

Good

Surgery services were managed by the Surgery and Critical Care business group management team, which included medical, nursing, governance and operational managers with responsibility for both surgery and critical care core services. The team was visible, approachable and competent team of managers who were passionate and proud of their department and hospital and worked hard to

improve services and maintain standards in a difficult and changing landscape. They had a plan for the future to help them to manage the challenges they would face in the restructuring of Greater Manchester's surgical services.

Staff felt supported by their managers and enjoyed their work even though it was hard work and very busy at times. Staff were pleased to be moving into a new theatre complex and were optimistic about the future. Staff told us that surgical services was a very nice place to work.

Vision and strategy for this service

- The trust had a five year strategy which focused on quality and sustainability. They were looking to restructure and reduce the services they provided moving away from the traditional model of the district general hospital.
- The trust planned to focus their service provision around care of older people and people with cancer and they planned to deliver more of the care they provided in the community and where possible in people's own homes.
- Surgical services were involved in the 'healthier together' programme which was planning the future of emergency surgery for the region. Provisional plans for Manchester generally, were to arrange delivery into sectors with the Stepping Hill hospital site key to the south east sector provision.
- They planned to work in partnership with other organisations and neighbouring trusts to provide a range of surgical services but that they would provide fewer services directly from Stepping Hill.

Governance, risk management and quality measurement

- There was evidence of effective clinical governance procedures and quality measurement these processes enabled risks to be captured, identified and escalated through different committees and steering groups. This enabled the dissemination of shared learning and service improvements and an avenue for escalation to the trust board.
- A monthly business group governance and risk meeting took place to discuss emerging and existing risks, these were regularly reviewed regularly and action plans were reviewed and updated.
- Managers and staff were aware of departmental risks, performance results, recent never events, serious incidents and other quality measurements. Information relating to key performance indicators such as safety, quality and performance was monitored and cascaded to staff through performance dashboards. Such information was used to identify areas for improvement and we saw evidence that this was being done on individual wards and in theatres.
- There were regular staff meetings and safety huddles to discuss prominent issues and to share information regarding incidents, audit results, complaints and patient feedback. Important information was also shared on notice boards and around wards and theatre areas.
- Individual ward managers sampled aspects of care and treatment each month, such as documentation, medicines management and discharge planning and thoroughly reviewed patient care and records. Any issues were brought to the attention of staff in order to improve quality.

Leadership of service

- The surgery and critical care group was led by approachable and visible service leads, who were positive and passionate about their service.
- There were clearly defined leadership roles across surgical services. Services were divided into clinical directorates based on specific surgical specialties and each speciality had a clinical lead.
- Staff from theatres and the wards staff understood the reporting structures fully and they said they felt well supported by managers.
- Managers undertook events to engage with staff, understand their issues and improve morale, staff retention, team work and performance.
- Individual ward managers appeared enthusiastic, competent and hard working. They were very well thought of amongst ward staff and led by example.

Culture within the service

- Staff were happy working at surgical services, whilst they told us it was very busy, they stated that they were well supported within their teams and spoke very highly of their individual ward managers.
- Staff were encouraged to express their concerns and speak openly so that action could be taken and

improvements made. We were told that staff felt there was a good 'no blame culture'. A trust had recently appointed a 'freedom to speak up' guardian in line with national initiatives.
- Morale was good across wards and staff told expressed "I would never want to work anywhere else". In theatres, morale had improved greatly following engagement meetings with staff, increases in staffing levels and action to address concerns. Staff now report they are "very proud of their theatre family".
- Staff were optimistic about their future and were looking forward to moving into their new surgical centre which they believed would improve their working environment and the service greatly.

Public engagement

- Business and operational plans for Stockport NHS Trust were available online to the public via their website and gave information about performance and strategic plans for the Trust.
- A wide range of information including policies and procedures, condition specific advice and information about the hospital was available via the trust website.
- The website provided information on how patients, carers and relatives could provide feedback to the trust and offered a number of ways to do so 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.
- Theatres arranged an 'Operation!' tour our operating theatres' event in September 2015 which gave members of the public a chance to look around the operating theatres.

Staff engagement

- The trust engaged with staff using newsletter, bulletins, emails and through the display of information on notice boards.
- Staff were able to access information electronically to enable them to keep up to date with policy and practice, latest safety alerts and trust strategy and developments.
- The trust undertook an annual event to recognise and celebrate the achievements of wards and individual staff.
- Following a recent incident in operating theatres managers identified poor morale amongst staff. They arranged an open forum with senior managers to express concerns and raise issues in a supportive and blame free environment. The concerns of staff were raised and anonymity was protected, 80 staff attended and the event which proved effective. This was followed up by a further feedback as 'you said we did' to show staff what had changed and what was done to improve issues. A subsequent event was held where feedback was given and future regular events were planned. This is believed to have helped improve morale and improve safety in theatres.

Innovation, improvement and sustainability

- The trust's five year strategy included social, financial and environmental sustainability. Given the changing landscape, they had plans to try to ensure the sustainability of the surgical services at Stepping Hill by reduced the range of surgical procedures they provided and focussing on care of older people and people with cancer.
- Discussions were ongoing with Manchester 'healthier together' programme and there was consideration that Stepping hill might become a specialist centre for colorectal surgery.

Critical care

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

Information about the service

The critical care service at Stepping Hill Hospital is delivered in two adjoining clinical areas on the first floor of the main hospital building. There is an eight bedded high dependency area caring for adult patients with an acuity of level 2 and an intensive care unit currently commissioned to provide level 3 care for up to seven adult patients. The unit admits around 650 patients a year and is an active member of the Greater Manchester Critical Care Network. The unit does not provide critical care for children. The trust website does not refer to critical care amongst the services offered at the hospital.

For the purpose of management and governance, the critical care service sits in the Surgery and Critical Care Business Group, which also includes theatres, anaesthetics and the pain service.

During the course of the inspection visit we spoke with 7 relatives and over 35 staff of all grades, nursing, medical and allied health professionals.

Summary of findings

We have judged that overall, the critical care services provided at Stepping Hill Hospital were good.

There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. We found a culture where incident reporting and learning was embedded and used by staff.

There was strong clinical and managerial leadership at unit and business group level. The unit had a vision and strategy for the coming years developed in accordance with the 'Healthier Together' proposals for Greater Manchester.

There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.

There were challenges with access and flow within the wider hospital which impacted on patients' discharge from the critical care unit. For the period 2014/2015, 69% of patients in critical care experienced a delay on discharge of longer than four hours.

Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

Critical care

Are critical care services safe?

Good

Overall in terms of safety, we judged that the critical care services at Stepping Hill Hospital were good.

There were systems in place for reporting and learning from incidents. There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients. The recent recruitment drive and negotiation of enhanced rates for existing staff meant that the risk rating for nurse staffing had recently been reduced.

We did identify a concern relating to the pre-filling of anaesthetic rapid sequence induction drugs and their storage. This was raised during the inspection and prompt and appropriate action was taken by the critical care staff to rectify the issue.

The facilities and environment generally met with the latest health building note guidance. Infection control practices were complied with resulting in low infection rates. The critical care services collected and submitted performance data nationally to enable benchmarking against comparable units. In terms of unit acquired infection rates the adult general level 3 and level 2 facilities performed better than comparable units.

Incidents

- The hospital had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff knew about the incident reporting system and were able to give examples of when they had used it.
- Incidents were also shared and discussed at daily safety huddles.
- There had been no falls and no catheter acquired urinary tract infections reported between September 2014 and September 2015. Between October 2014 and October 2015 there had been no never events in critical care but four serious events had been reported (two pressure ulcers, one alleged abuse and one health care acquired infection).
- For the period November 2014 to October 2015, the data shared as part of the provider information request, reported 337 incidents occurring in critical care. These related to a range of events including medication errors, delayed discharges greater than 4 hours, staffing shortages, identification of pressure ulcers on admission to the unit and clinical incidents.
- Minuted monthly critical care mortality and morbidity meetings were held. Incidents that had occurred since the previous meeting were discussed. The learning was taken and actions instigated. For example, critical care staff had been going to assist ward staff by setting up a blood warmer for a patient who required a post-operative transfusion. It was accepted that the responsibility for training ward staff in the use of the blood warner did not rest with critical care staff and it was deemed unsafe for staff to leave the unit, possibly short staffed, to facilitate such assistance in the future. Any out of discharges were also considered and discussed at the mortality and morbidity meetings.
- We asked staff about their understanding of the principles of 'duty of candour'. Whilst senior nurses were able to explain what was meant by the term, none of the band 5 nurses that we spoke with were familiar with what was meant by 'duty of candour' and couldn't recall having had any training on the subject. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms and 'harm free care' once a month. This included data on patient falls, pressure ulcers, urinary catheter related infections and episodes of venous thromboembolism (VTE). Safety thermometer data was submitted from the unit and reported at business group level via a clinical safety dashboard.
- Safety thermometer data was displayed in the corridor outside the clinical areas just through the critical care entrance door. Alongside was also displayed the staffing information for the day and night shifts, in terms of actual versus planned trained nurses and health care assistants on duty.

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.

Critical care

- The trust had infection prevention and control policies in place which were accessible to staff.
- Throughout the inspection we observed staff appropriately washing their hands, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care.
- The critical care unit was subject to both monthly audits of hand hygiene, cannula and catheter care. The results for hand hygiene showed a significant improvement in compliance over the course of 2015 although there were two months with no data. For catheter care the results showed 85-100% compliance and for cannula care again there had been improvements in compliance through 2015 with a rate of 87-100%. In addition to the monthly audits there was also an annual infection prevention audit, which looked at the environment, universal precautions including the management of sharps, managing indwelling devices and the staff's understanding of the prevention and management of infections. This section included the transport of specimens. The last report shared with us from October 2014 showed some areas where the unit had fallen short of the expected standard in terms of cleanliness, the management of sharps bins and documentation of cannula checks. It is following this annual audit that the monthly audits of hand hygiene, catheter and cannula care started to improve.
- The most recently validated ICNARC data showed that the unit generally performed better than comparable units for unit acquired infections in blood. This was the case for ventilated patients, elective and emergency surgical admissions. For unit acquired Clostridium difficile infections the unit also performed better than comparable units though for unit acquired methicillin resistant staphylococcus aureus (MRSA) the unit was at times not as good as comparable units. This applied to the presence of MRSA in any sample taken for microbiological examination 48 hours after admission to the unit. However, there were no cases of unit acquired MRSA in blood infections reported.

Environment and equipment

- The critical care unit as a whole does not comply fully with the most recently available health building guidance, HBN 04-02. The areas of non-compliance relate to the availability of ceiling hoists and the availability of positive and negative airflows in the isolation rooms. The trust is well aware of this and the issue is on the business group risk register.
- The level 2 patient area has been built within the footprint of what was previously a ward. So this meets the patients need for single sex accommodation and also contains additional bed spaces that will allow for expansion of the level 2 provision. It also allows for the care of a level 3 patients should this be a clinical requirement. The bay at the end of the level 2 facility is also equipped for and used as a simulation training area.
- All bed spaces were fully equipped with the kit required to care for a critically ill patient.
- The electro biomedical engineering and maintenance department (EBME) undertook all the servicing and maintenance of equipment. Detailed records were kept of all equipment alongside a service and maintenance database.
- The unit has a capital replacement programme and has recently purchased new mattresses and high flow oxygen machines. Some central monitoring equipment is due for replacement in 2016.
- We saw that resuscitation equipment; including defibrillators and difficult airway management trolleys were available. Records indicated that these were all checked daily against a laminated contents list, then signed and dated.
- Nutritional supplements were stored in the visitors' kitchen. This room was not temperature controlled or secure

Medicines

- The unit used an electronic prescribing system, which could be accessed at the bedside.
- In both level 2 and level 3 clinical areas the medicines were kept within an open plan area of adjacent to the nurse station. They were not behind a locked door but the area was subject to video surveillance.
- Regularly used intra-venous fluids were kept in an unlocked racked storage system for easy access.
- Controlled drugs were stored in separate locked cupboards with the keys being held on the person of the nurse in charge of the shift.

- Controlled drugs were subject to a daily check, usually carried out in the evening. We undertook a check of the controlled drugs during the inspection and found that they were all in date and the stock number tallied with the controlled drug record book.
- Controlled drugs brought in or belonging to patients were recorded in a separate register.
- We noted low stock levels of controlled drugs and were told by staff that they purposefully only stored the controlled drugs that they needed for the patients in the unit at any one time. So they didn't keep excess stock.
- Intravenous potassium chloride was also kept securely in a locked cupboard and its expiry dates were checked daily.
- In the level 3 (intensive care unit) there was an unlocked drug fridge. On checking this we found a plastic tray containing a number of syringes pre-filled with intra-venous injections to be used in the event of a 'crash intubation'. A 'crash intubation' or rapid sequence induction is an advanced airway procedure that is used to secure a patients airway with the placement of an endotracheal tube with minimal delay following the administration of hypnotic and muscle relaxant drugs. It is a procedure used in situations where there is an increased risk of regurgitation and subsequent inhalation of gastric contents. The tray was labelled with the date, time and name of the doctor but the individual syringes were not appropriately labelled. This practice of pre-drawing up intubation drugs had not been undertaken with prior involvement of the pharmacy team, who would have commented on 1) the risks associated with this practice 2) the efficacy and stability of the pre-prepared drugs. We raised our concerns about this practice there and then with the senior nurses on duty. We were told it was the established practice of just one doctor, who when on duty at night, would pre-draw up these drugs just in case they were needed during the shift. We requested that the practice cease immediately and also that a risk assessment be carried out on the use of the drug fridge. The senior nurses on duty responded promptly and appropriately by disposing of the drugs. We were informed that the doctor in question would also be asked not to continue to pre-draw the 'crash induction' drugs up in advance.
- When we returned to the level 3 area the next morning there we no longer any pre-filled syringes in the fridge and a lock had also been added to the fridge to secure its contents, which included insulin and noradrenaline.
- The critical care unit had dedicated senior pharmacy input but the allocated whole time equivalents fell below the intensive care society standards. There should be 0.1 WTE for every level 3 bed and 0.1 WTE for every two level 2 beds. So for the Stepping Hill Hospital unit that meant for seven level 3 beds and eight level 2 beds there should be 1.1 WTE and there was actually only 0.4 WTE allocated.
- In November 2014, an incident (no 121619) was reported that the drug fridge was untidy, "drugs were thrown in and mixed with other drugs". The fridge was duly emptied, tidied and some drugs were found to be out of date and were returned to the pharmacy. This incident served to illustrate the issues with the under resourced pharmacy allocation to critical care. A shortage of pharmacy technical staff combined with the unit staff being busy meant that expiry date checks were not taking place as frequently as they should have.

Records

- We looked closely at six sets of patient records. The medical/nursing records were paper based and comprised a range of clinical records, assessments and plans. These included for example, VTE risk, delirium, nutritional risk, falls assessments, physiotherapy treatment plans and skin care bundles. All entries were completed, signed and dated.
- All patients had been seen and reviewed soon after their admission. Their daily medical review and plan was also present.
- Although entries in records were signed and dated and in most cases included the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- Physiological parameters were recorded by the nurse looking after the patient on a large chart located close to the bedside. The charts that we looked at were comprehensively and accurately completed and brought together in one place all the patient's physiological monitoring, blood results, care planning and management.
- The unit was using electronic prescribing, which was accessed via a bedside laptop. Electronic prescribing has been shown to have an impact on patient safety by reducing medication and transcription errors.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding training was part of the trust mandatory training programme. The figures shared with us during the inspection were measured at business group level. For the surgery and critical care business group 93% of staff had completed level 1 children's safeguarding training and 89% had completed level 2 children's safeguarding training. For adult safeguarding, 91% were reported as having completed level 2 training. It should be noted that the unit did not provide critical care for children.

Mandatory training

- Mandatory training figures where kept at business group level and were reported as follows: manual handling 84%, equality and diversity 87%, venous thromboembolism prevention 76%, basic life support 61%, level 1 child safeguarding 93%, information governance 78%, mental capacity act 82%, level 2 safeguarding adults 91% and level 2 safeguarding children 89%. The reports that were shared with us did not indicate the date at which these figures were taken.
- The records also highlighted those staff that had not completed their mandatory training.

Assessing and responding to patient risk

- The wider hospital used a patient tracking system. (This was not being used in critical care). The system allowed automatic alert and escalation of deranged physiological parameters linked to the EWS. This ensured that the most appropriate clinicians were informed when a patient became acutely unwell and so ensured a timely response their deteriorating health.
- Clinical observations were recorded at the bedside onto a tablet. The software then calculated the EWS and where appropriate cascaded an alert to medical and nursing staff.
- The patient tracking interface allowed clinicians to see where the sickest patients were in the hospital and to remotely view their observations.
- The alert only stopped when an appropriate level of response and/or reduction in the EWS occurred. We were told that there had been a reduction in the number of incidents relating to EWS scores since the introduction of the electronic patient track and trigger system.
- We asked if there were any audit data available that evaluated the effectiveness of what was a relatively new patient track and trigger system but none were available.
- The current model for referring a patient to critical care was on a consultant to consultant basis. So if a patient on the ward or in the emergency department was causing concern and needed assessing, this was undertaken by the critical care consultant. There was no nurse led critical care outreach team. Patients once discharged to the ward were sometimes followed up by the critical care advanced nurse practitioner (ANP). Though this arrangement had not been formalised. If the ANP was concerned about a patient then they had access to an on-call consultant for advice. We were told that with the outcome of 'healthier together' in Greater Manchester, it is anticipated that an outreach service will be considered as part of the critical care service expansion. The current lack of a formal critical care outreach had not been flagged as an issue by the Greater Manchester Critical Care Network.

Nursing staffing

- The Intensive Care Society patient acuity measure was being used to determine the number of staff required on duty. The numbers of planned versus actual nursing and support staff per shift was displayed at the entrance to the unit.
- At the time of the inspection, there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment. There was a supernumerary shift co-ordinator in both level 2 and level 3 clinical areas.
- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers.
- The 2015 Greater Manchester Critical Care Network review included concerns about night time medical cover, staff recruitment and retention and the shortage of appropriately senior dedicated pharmacist time. We saw that all the areas of concern had been reviewed by the unit and action plans developed.
- The past 12 months has seen nurse recruitment and retention as the number one risk to the critical care service. A number of initiatives have been introduced to try and stream line the recruitment processes and also

to provide additional training to those agency staff that were regularly used. Enhanced rates have also been negotiated with NHS Professionals to make working additional shifts more attractive for the unit's own staff.
- The aforementioned initiatives have meant that the critical care unit has been able to keep its beds open and maintain the service. The position in respect of recruitment is now much healthier with just four band 5 and one band 6 vacancies. The recent recruitment and enhanced rates for the unit's own staff have meant a reduction in the risk rating has been possible.
- A structured handover took place between the two shifts; this included a bedside nurse to nurse handover.

Medical staffing

- There was a named clinical director and 14 critical care consultants supported by trainee medical staff for the critical care services. All consultants were Fellows of the Faculty of Intensive Care Medicine (ICM) with direct daytime critical care clinical activity present in their job plans.
- The consultant team provided full session day time cover. Evening and weekends were covered by a weekend day session and on call out of hours. Consultant was available 24/7 and available within the 30 minute travel timeline.
- Out of hours there was one trainee covering both level 2 and level 3 areas. On occasions they may have to go to the emergency department but did not have any theatre or maternity theatre responsibilities when on duty overnight. No foundation level doctors were ever left as the sole doctor in critical care.
- There had been reported incidents of delays in patient care and treatment as a consequence of a doctor not being immediately available overnight.
- Generally the workload was 1:8 but could go to 1:14 is the consultant was covering both level 2 and 3 areas.
- Clinical consultant led ward rounds took place twice a day, seven days a week.
- A structured consultant to consultant shift handover took place.

Major incident awareness and training

- Working with national legislation and guidance such as the Civil Contingencies Act (2004) and the NHS Emergency Planning Guidance (2005), the critical care services had detailed plans for responding to the increased demands that a major incident would make on services, while continuing to provide care for existing patients.
- The major incident policy was easy accessible on the trust intranet and was last reviewed in August 2015.
- Staff told us that they had been required to evacuate the unit for a problem with the ceiling.

Are critical care services effective?

Good

Care was delivered in line with evidence- based, best practice guidance. In order to benchmark its performance against comparable units the critical care service collected and submitted data to the intensive care national audit and research centre (ICNARC) for validation. The latest validated data showed that patient outcomes and mortality were generally within the expected ranges when compared with similar units nationally. The exception being for delayed discharges where the unit's performance was slightly worse than the England average.

As part of their individual care plan all patients in critical care were assessed in respect of their pain management. Ward rounds took place each day that involved medical, nursing, pharmacy and other allied health professionals as required. Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE). For example, NICE guidance 83, 'Rehabilitation after Critical Illness'.
- The critical care unit demonstrated continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The critical care units were also subject to an annual peer review by the Greater Manchester Critical Care

Network (GMCCN). The purpose of the reviews was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.

- Following the most recent GMCCN review, in May 2015, the critical care service fully met the majority of the specification requirements. The GMCCN had no immediate or serious concerns. However, the GMCCN did report some concerns that required consideration and action. Notably, many of their concerns had been reported in the previous annual review (2014) but remained outstanding following the 2015 GMCCN review. These included issues related to patient access and flow, which have been discussed in the response section of this report.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust wide intranet.
- We saw evidence of a range of local audit activity, which included assessments of compliance with care bundles relating to ventilator acquired pneumonia (VAP), the management of central venous catheters, indwelling urinary catheters and NICE guidance 50 'Acutely Ill patients in Hospital'. The results generally showed good levels of compliance. However, the compliance with ventilator bundle audit results that we saw did show less than 100% compliance at times with one or more of the parameters. For example, the October 2015 results showed 60% compliance with sedation hold. VAP audit results we saw did show. Audit results were discussed at the critical care team meetings and were published in the newsletter.

Pain relief

- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a paper based pain scoring tool. Staff told us that pain assessment was part of 'intentional rounding' and patients were asked whether they had any pain every hour.
- The unit had a 'link' nurse for pain management and referral was made to the hospital pain team as required, though the pain team visited the unit daily anyway. Both epidurals and patient controlled analgesia systems (PCA) were used, mainly in the level 2 or high dependency area. Link nurses are part of a system that shared information and provided formal, two-way communication between specialist teams and nurses in the clinical area.

Nutrition and hydration

- Evidence based guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately in the patient's notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.

Patient outcomes

- We were provided with the latest validated and published ICNARC data for the period April to June 2015, which benchmarked the unit against comparable units nationally.
- For the period April to June 2015, data showed that for ventilated patients, mortality was similar to or even better than comparable units although the mean length of stay was longer. The same outcomes applied to patients admitted with severe sepsis, pneumonia and elective surgery over the same time period. For emergency surgical admissions and trauma the mortality figures where better than for comparable units.
- For all unit acquired infections, the unit performed better than comparable critical care units.
- In terms of outcomes for patients the worse performing area shown in the latest ICNARC data was for delayed discharges. Over 50% of the recorded delays were for greater than 4 hours but less than 24 hours and approximately 11% of patients waited between one and two days to be discharged once they had been judged clinically as fit to do so.
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and this has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress.

Competent staff

Critical care

- Staff were appropriately trained, competent and familiar with the use of critical care equipment.
- The critical care unit had a designated full time clinical practice nurse educator in post.
- Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- All staff should receive an annual appraisal. According to the data, by December 2015, 100% of critical care medical staff and 78% of critical care nursing staff had received their appraisal.
- All new staff to critical care worked through an induction programme; this was given to them by the practice educator on their first day into the clinical department. The length of this programme depended upon prior knowledge of the critical care environment and previous experience. Staff were supernumerary during this induction. The programme lasted from four to eight weeks, or longer if the nurse did not feel ready to go into the staffing numbers. This was supported by an individual action plan. In addition to any critical care related induction new staff to the trust undertook a mandatory trust induction as well.
- Staff new to critical care also worked through the Step 1 competencies developed for critical care by the national Competency Framework. There was an expectation that these competencies would be completed within 12 months. Following completion, Step 2 competencies would be completed. It was at this point that applications could be made to access the post registration critical care course. There had been a number of staff leave the unit during the past 12 months so the percentage of staff that had completed the critical care course had fallen from about 75% to nearer 50%. Usually five to six nurses per year were supported to undertake the critical care course.
- All nurses working in critical care had completed basic and intermediate life support training. The advanced nurse practitioner had also completed advanced life support training (ALS).
- The practice educator was also involved in delivering a programme of study days not just for critical care staff but also included nurses working in the wider trust. For example, specific training on the management of patients with a tracheostomy.
- The practice educator was also responsible for overseeing the placement of student nurses on the unit.
- When agency nurses were used, the unit tried to obtain nurses who had regularly worked on the unit to provide some consistency. Agency staff had their competencies assessed before they worked unsupervised.
- The unit had been nominated for a 'certificate of excellence' as recognition that it provided an outstanding learning environment.

Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place each day. Although members of the multi-disciplinary teams attended at some point during the day they did not always attend at the same time. For example, the dieticians would attend around noon and the microbiologists around 14.00. Staff explained that this arrangement made best use of the multi-disciplinary team's time.
- There was also evidence of multi-disciplinary working around the discharge of patients involving medical, nursing and allied health professional staff.
- The full-time practice educator for critical care worked closely with the unit team, especially the newer and less experienced staff as they worked through their competencies. The practice educator was also involved in teaching on the critical care course and also providing specialist training within the wider trust. For example, in the management of patients with tracheostomy.
- There was no formal funded critical care outreach team and no post hospital discharge clinic for critical care patients. Though we were told that there were plans to develop both outreach and follow up opportunities in the future as the service developed.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours.
- The physiotherapy team also provided a seven day service to the critical care unit during the day with an on call service out of hours.
- Dietetic and pharmacy services were available Monday to Friday and via on-call at weekends.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

Access to information

Critical care

- The critical care unit used a single multidisciplinary paper based record system for each patient in which was recorded all the multi-disciplinary team's notes. This was located by each patient's bedside. The only electronic records were those relating to the prescribing and administration of medicines. These were accessed via a bedside laptop. This electronic prescribing system was also used on the wards, which enabled safer transfer and management of medicines information on discharge.
- All the patient's physiological parameters, assessments, fluid balance and ventilator settings were recorded on a large critical care observation chart situated by the bedside.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information between relevant health and social care professionals.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care. There was a good understanding of the Mental Capacity Act 2005 and the associated deprivation of liberty safeguards.
- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient. Care plans stated that the CAM-ICU should be completed once every shift but this was not always evident in the six sets of patient records that we examined.
- Staff were able to explain the use of the 'do not attempt resuscitation' (DNACPR) forms, although there were no patient records on the unit during the inspection, where these forms were being used.

Are critical care services caring?

Good

Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.

The unit had developed and implemented a multi-faith bereavement service that was held in high regard by both families and staff. It was run by a team of likeminded critical care nurses, often in their own time, providing a source of sensitive support for families as they dealt with the grieving process.

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Privacy curtains were drawn around people with appropriate explanations given prior to care being delivered.
- We spoke with the relatives of patients on both clinical areas. They were universal in their praise for the medical and nursing staff. They told us they had been kept informed of everything that was going on with their relative. These views were supported by the results from the unit's own patient and relative feedback questionnaire analysis.
- The unit ran a memorial service twice a year which was held in the hospital chapel. There was an order of service which included readings, songs, music and a candle lighting ceremony. Refreshments were served after the event with the opportunity for families to meet with staff again from Critical Care. This event was extremely well evaluated and we saw written testimony from relatives who valued the event.

Understanding and involvement of patients and those close to them

Critical care

- Staff communicated with patients and those close to them so that, where possible, they understood their care and treatment.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- The unit was using patient diaries, where appropriate. Usually for patients who are sedated and ventilated. Intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress. In addition to trialling patient diaries the critical care outreach team were also filming patients as part of the patient stories project. Where patients talked about their experience of critical illness and the care they received on the units.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a senior nurse for organ donation in post who worked closely with the critical care team in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- Some staff on the unit had developed a bereavement team and over time had introduced the use of a bereavement box on the unit. This brought together in one place, information and materials that enabled the staff to better manage the end of life care for their multi-faith patients. For example the box contained the equipment needed to take hand prints and locks of hair as keepsakes. There were also copies of the Bible, the Koran and The Torah.
- The bereavement team met formally twice a year to share experiences and reflect on the service provided. The staff involved were from nursing, medicine and chaplaincy backgrounds and were passionate about providing excellent end of life care. The critical care unit also hosted two memorial services each year for ex-patients and their families at the hospital's chapel. We saw evidence of written feedback from families detailing how helpful and supportive they had found the services. Much of the work of the bereavement team was undertaken in their own time.
- The unit was not yet able to provide a follow up appointment for discharged critical care patients though this was articulated by staff as being an aspiration for the future as the critical care service at the hospital developed.

Are critical care services responsive?

Requires improvement

We judged that in terms of responsiveness, the critical care service required some improvements to better ensure that people's needs were met.

There had been improvements in reducing the number of patients discharged out of hours. However, challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care unit. For the period 2014/2015, 69% of patients in critical care experienced a delay on discharge of longer than four hours.

Service planning and delivery to meet the needs of local people

- In accordance with the 'Healthier Together' proposals for Greater Manchester, Stepping Hill Hospital has been chosen of one of only four sites to provide emergency medicine and specialist abdominal surgery. This will mean an expansion of the critical care service to include an increased number of level 2 beds at Stepping Hill Hospital.
- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.
- There were facilities for relatives to stay on the unit if they wished to and overnight, if needed, in a close by bedroom.

Meeting people's individual needs

- Patients were reviewed in person by a consultant within 12 hours of their admission.
- Care plans demonstrated that people's individual needs were taken into consideration before delivering care.

- Interpreting services were available within the hospital if required.
- There was no formal funded critical care outreach service provided in the hospital. Though on occasions patients were seen after discharge from critical care by the unit's advanced nurse practitioner (ANP).
- The latest available intensive care national audit and research centre (ICNARC) data showed that the unit was performing better than comparable units for early readmissions and post unit hospital deaths. Early readmissions are classified as being unit survivors that are subsequently readmitted to the critical care unit within 48 hours of discharge and post unit deaths are classified as being unit survivors that die before ultimate discharge from acute hospital, (excluding those discharged for palliative care). In 2014/2015 there were 21 readmissions but only two of these were within the 48 hour timeline.
- We saw that care for people with a learning disability was sensitive, supportive and appropriate.

Access and flow

- Monthly key performance data showed that bed occupancy in critical care for the period April to October 2015 was between 67% and 82%.
- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from intensive care there was often a delay in discharge.
- In 2014/2015, 476 patients out of a total of 692 experienced a delayed discharge of more than four hours. This represents 69% of patients facing a delay in their discharge.
- This position was not just being accepted though and work was being undertaken to review the discharge protocols for critical care, with the aim of improving the delayed discharge figures. This included working closely with bed managers so that they better understood the discharge priorities for critical care. Unit staff attended the bed management meetings when possible and monthly reports on discharge waits were reported to the business group quality board.
- Out of hours discharges were also closely monitored. For the period 2014/2015 there were 35 night time discharges, predominantly to surgical wards. According to the ICNARC data this performance was generally better than comparable units. As part of the wider work on patient pathways and bed management, the unit's staff were working collaboratively with business group colleagues to better understand the processes that were causing out of hours discharges.
- These access and flow pressures had an impact on operational effectiveness. For the year 2014/2015 there had been 56 cancelled elective surgery cases. These had been for a variety of reasons not just the lack of a critical care bed. For example, when an emergency patient would take priority over an elective case.
- During the past twelve months there had been 12 occasions when a level 3 patient had been cared for in theatre recovery whilst awaiting a critical care bed. Six of the aforementioned patients were admitted to critical care within four hours, three were admitted between four and ten hours and one patient remained ventilated in recovery overnight. During the time these patients were cared for in the theatre recovery they were looked after by medical and nursing staff with the appropriate skills and competencies.
- The accommodation in critical care and availability of side room meant that mixed sex breaches could be avoided. On checking the incident register there were no instances of mixed sex breaches being reported. This fact was corroborated by also looking at the NHS England mixed sex breaches data.
- ICNARC data showed that there had been low numbers of non-clinical transfers out when compared with similar units. This reflects well on unit performance and indicates that they usually managed to accommodate patients for admission rather than having to move them for non-clinical reasons, like having no available bed. In 2014/2015 there were just four non clinical transfers, which according to the ICNARC data demonstrated better performance than comparable units for this outcome measure.

Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns. These included defining who was responsible for managing complaints, the timescales for investigations and responses to complainants and the governance pathways through which complaints were reported from ward to board. Learning from complaints, concerns and compliments was triangulated within the division alongside other patient experience and feedback.

Critical care

- The trust's website contained information on how to raise a concern both informally and as a formal complaint.
- We had no specific complaints data relating to critical care in terms of numbers and specific lessons learned though staff told us that there were very low numbers of complaints for critical care.

Are critical care services well-led?

Good

Overall, we judged that the critical care service at Stepping Hill Hospital was well led.

There was strong local and business group clinical and managerial leadership and the unit had a business plan and strategy for going forward. There was a clear governance structure to ensure that performance was monitored, reported, shared and challenged from ward through to board.

The critical care service was effectively engaging with staff and patients to inform the improvement and development of its delivery.

Vision and strategy for this service

- Staff were able to describe the developmental vision for the unit at both business group and unit level. Stepping Hill Hospital has been chosen as one of only four sites in Greater Manchester to provide emergency medicine and specialist abdominal surgery, under the 'healthier together' proposals. The impact of these proposals is a likely increase in the number of level 2 beds provided for predominantly post-operative care. The level 2 facility at Stepping Hill Hospital already has in its existing footprint the capacity to expand the number of level 2 beds provided. There are already the required number of bays and bed spaces with the required services, such as piped gases and suction. So it would be a case of then providing the additional equipment and staff to enable the planned growth of level 2 beds.

Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board. This included a monthly business group governance and risk meeting at which all existing risks were reviewed and new risks were assessed and added along with intended actions.
- Critical care risks were included on the Surgery and Critical Care business group risk register. The risk register provided by the hospital prior to the inspection showed the leading risks for critical care on 4th November 2015 were staffing, compliance with the network service specifications and the need to replace ageing monitoring equipment. We received an update on these risks during the inspection and it was clear that the recent recruitment initiatives had improved the staffing position so that the risk had been reduced as shown by the latest risk register review.
- The unit was subject to annual peer review benchmarking by the Greater Manchester Critical Care Network against the present evidence base and agreed standards for critical care provision. The most recent review by the network had been in May 2015. The network report identified some concerns, none of which were of immediate or serious concern, for which the critical care unit had developed an action plan, which is due for review in February 2016.

Leadership of service

- The critical care unit had a designated consultant clinical lead and the nursing team was led by a team of experienced senior nurses. There was clear and strong leadership at unit and business group level with staff who had with the skills, integrity, capacity and capability to lead the service effectively.

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care.
- Staff were encouraged to report incidents and raise concerns.
- We asked staff about their understanding of the principles of 'duty of candour'. Whilst senior nurses were able to explain what was meant by the term, none of the band 5 nurses that we spoke with were familiar with what was meant by 'duty of candour' and couldn't recall having had any training on the subject.

- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- We asked staff about their understanding of 'duty of candour' and what training was provided in this regard. None of the band 5 nurses that we spoke with were quite sure what was meant by duty of candour and could not recall having had any training on the subject.
- We were also told by nursing staff that there was an expectation that they often had to attend essential training, for example on critical care equipment, in their own time. So as a consequence they were not paid for the hours they committed to attending such training.

Public engagement

- The trust website did not include any details about the critical care service provided at Stepping Hill Hospital as part of the section called A-Z of services.
- The noticeboards in the critical care unit relative's rooms displayed a range of helpful and supportive information and contact details, including how to make a complaint or raise a concern.
- Whilst the unit did display information about visiting times, we heard from both staff and relatives that visiting was at the discretion of the nurse in charge and exceptions were often made to allow relative's to visit their loved ones.
- Stockport NHS Foundation Trust has more than 17,500 staff and public members. It produced a members newsletter quarterly called 'Stepping Up', which included updates on the development of critical care in accordance with the 'healthier together' proposals.

Staff engagement

- A meeting was held in September 2015 to share and discuss the implications of the 'healthier together' initiative on the critical care services at Stepping Hill Hospital.
- The critical care unit's Matron produced an informative monthly newsletter. Copies of which were available in the staffroom. It contained a wide range of useful and informative articles, including the learning from incidents and investigations not only in critical care but in the wider trust.
- Following the results of the last NHS staff survey, the trust had put together an action plan for the future development of its workforce. One of the initiatives was to increase staff engagement and communications and one of the measures was to refresh the existing 'Visibility Walkabout Programme' for the executive team and senior leaders. Staff told us that the unit did receive visits from senior leaders from within the trust.

Innovation, improvement and sustainability

- The hospital produced a member's newsletter, which communicated the key changes to the way that services are to be provided in the future alongside current successes. For example, having been confirmed as a 'specialist hospital' site as part of the 'Healthier Together' consultation means that services will need to develop and adapt to deliver emergency medicine and specialist abdominal surgery services to its patients. There is also to be a focus on key patient groups such as older people with chronic conditions and frailty.

Maternity and gynaecology

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

Information about the service

The trust offers pregnant women and their families antenatal, delivery and postnatal care at Stepping Hill Hospital. The department delivered approximately 3,500 babies every year. A range of gynaecology services and a termination of pregnancy service was also provided.

The Women's unit occupied four floors of one wing of the hospital. There was a separate entrance with drop off parking for the delivery suite away from the main hospital. There was a consultant led delivery suite with nine birthing rooms plus nine single en-suite rooms, a midwifery led birthing centre with four LDP rooms plus a four bedded post natal bay and one maternity ward which had 28 beds used for either ante natal or post-natal care. The obstetric theatres were situated adjacent to the delivery suite. There was a pregnancy assessment unit consisting of maternity triage and an antenatal day unit with six single assessment rooms. An ante-natal clinic was on the ground floor of the women's unit.

One ward of 10 beds was specifically for gynaecology patients. There were four consulting and treatment rooms on this ward which were used to provide gynaecology procedures as outpatients.

There were four community midwife teams aligned to the our localities within Stockport. A further midwife team provides care to patients in the High Peak which is a rural area. There was a stand alone birth centre in this area; however this had closed in 2012 and community midwives continue to provide ante natal, post natal and home birth services in this area.

We visited the maternity department during the announced inspection between the 19 and 22 of January 2016. During our visit we spoke with 28 staff, 11 patients and five family members. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 11 patients. We also looked at five medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

We found maternity and gynaecology services to require improvement in terms of being safe, effective and well led. We found them good in terms of being caring and responsive.

There was a lack of learning and feedback from incidents to ensure necessary changes were made to prevent recurrence. Not all medicine administration practices met with best practice guidance and some steps in the safer surgery checklist were not completed during surgical procedures.

Half of the staff in maternity and gynaecology were not up to date with adult basic life support and the systems for checking emergency equipment such as that used for resuscitation did not provide assurance that it would be in full working order. There were around one quarter of midwives who were not up to date with their maternity specific training and annual appraisals and their competence to carry out some practices had not been assessed. Midwifery staff shortages meant some shifts had staff numbers below those set by the trust. Some actions had been taken to improve this. Medical staffing was sufficient on the wards; however there was a shortage of consultant cover in the ante-natal clinics.

Policies and procedures were up to date, easily accessible and in line with national guidance. Audits took place to monitor the quality of the service provided; however there was a lack of clarity about how any areas for improvement identified were monitored. There was no system for monitoring patient outcomes in maternity services to assess the quality of service delivered. Areas of potential concern we found had not been identified by the trust. Information gathered was not used to benchmark performance against other trusts or national targets.

Patients were complimentary about the attitude of staff and the way care was provided. They received timely pain relief. Systems were in place to offer good support for mothers who wished to breast feed. There were examples of effective multi-disciplinary working in obstetrics and gynaecology services and good access to services seven days per week. There was good record keeping including consent to care and treatment.

Actions had been taken to improve the safeguarding practices since the CQC review in December 2014. Specialist midwives were able to provide support for patients with additional physical and mental health needs; however the need for increased perinatal mental health support had been recognised.

The governance system had not identified several clinical issues we found. There was a lack of monitoring of performance against trust or national targets and therefore a lack of understanding of where improvements were necessary. There was no date of entry or review for risks on the divisional risk register. Not all risks that had been identified were recorded.

Multi-disciplinary staff had been included in discussions and felt they were being kept aware of potential changes in the service. Staff spoke positively about the leadership in their immediate area and in the wider trust Staff of all grades described an open culture with a sense of pride in the service they provided. Mechanisms were in place for engagement with users of the service. Staff told us they felt included, their views were sought and valued.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Maternity and gynaecology services required improvement in terms of being safe.

There was a lack of learning and feedback from incidents to ensure necessary changes were made to prevent recurrence. The systems for checking emergency equipment such as that used for resuscitation did not provide assurance that it would be in full working order with all items present if it was required. Some areas of the environment presented barriers to effective infection prevention and control. There was no input by the pharmacy department into the management of medicines and not all medicine administration practices met with best practice guidance. Not all steps in the safer surgery checklist were completed during surgical procedures.

Half of the staff in maternity and gynaecology were not up to date with adult basic life support. The remainder of the mandatory training was up to date. Midwifery staff shortages meant some shifts had staff numbers below those set by the trust. Some actions had been taken to improve this.

Medical staffing was sufficient on the wards; however there was a shortage of consultant cover in the ante-natal clinics.

Senior staff were completing the necessary actions within the duty of candour regulation. Records were accurate, up to date and securely stored. Actions had been taken to improve the safeguarding practices since the CQC review in December 2014. Additional training and changes to practices and procedures had resulted in greater safeguards for patients.

Incidents

- A process for the review of serious incidents and identification of any themes was included as part of the risk and governance management of the maternity services.
- There was no mechanism for a review of moderate and minor incidents to illicit themes and ensure appropriate actions were to be taken. We saw there was repeated use of phrases such as “correct procedure followed in immediate response to incident”. As there was no identification of repetition of these incidents there was no investigation into the cause or actions to prevent recurrence.
- When a serious incident occurred in the Child and Family business group there was a debrief within 24 to 48 hours to discuss any immediate concerns and appoint a lead to investigate. An immediate assessment would be undertaken considering the situation, background, analysis and recommendations (SBAR). Pending the full investigation this would be shared to ensure any immediate recommendations were implemented.
- Two initial incident reports we reviewed contained no information about what could or should have been done differently.
- The recommendation on one interim report was “Full root cause analysis to be completed”. On discussion with the relevant manager they told us there had been immediate actions.
- The actions discussed as having taken place centred on equipment malfunction. There was no acknowledgement that human error or poor practice may have occurred. Therefore there was no learning for midwives to prevent another occurrence pending the outcome of the full investigation. This was discussed with the manager at the time and whilst there was some agreement there were multifactorial reasons for the incident they had not addressed all possibilities in their initial investigation.
- The feedback from investigations was shared verbally with the band 7 coordinators who were expected to share it with their teams. Although trust managers told us there was a formal mechanism for this with written information shared ward staff were not aware. That meant staff may not receive feedback about prevention of recurrence of serious incidents.
- Midwives told us they did not always get feedback from incidents they had reported. A manager told us the electronic incident reporting system provided a function for feedback to the reporter however this was not in use. Some of the feedback from incidents was stored in a “keeping up to date file” in the ward areas and staff said they would look at this when they had time. It was recognised by managers that the system to provide feedback “needed to improve”.
- Staff in the Women’s unit did not receive information or learning from incidents which had occurred in the wider

trust. Any themes identified from incidents were discussed in the weekly managers meetings and the onus was then on the managers to disseminate this information to the rest of their team. Safety huddles did not take place and we were told this information would be shared at shift handovers. We did not observe this to occur.

- Monthly morbidity and mortality meetings took place. These were open to all doctor, midwives and students. Doctors of all grades were encouraged to present their own cases which were discussed. These included all patients who had returned to theatre, had a post-partum haemorrhage or any emergency during or post-delivery.
- Midwives received feedback from morbidity meetings if it was appropriate to their area of care.
- Managers we spoke with were aware of their responsibilities under the duty of candour regulations. We saw that meetings with patients had been offered when incidents had occurred.

Safety thermometer

- The specific maternity safety thermometer was not in use following recommendations by the leading advisory body. This is a point of care survey that is carried out on one day per month in each maternity service on all postnatal mothers and babies who consent to take part. Data provides a 'temperature check' on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for patients.
- The information from the general safety thermometer was displayed which included the number of falls and infections each month. This meant maternity specific harms such as perineal and/or abdominal trauma, post-partum haemorrhage and puerperal Infection were not measured in this way.
- On the gynaecology ward the safety thermometer information was displayed. This showed there had been harm free care provided on that ward.

Cleanliness, infection control and hygiene

- Most of the areas in the maternity services were visibly clean. Some areas were dusty such as emergency equipment, feet of chairs and some work surfaces. Monthly audits took place and those for September and October showed areas had been identified where furniture and fittings were marked and dust had accumulated. Actions taken included requests for new furniture, changes to cleaning regimes and additional cleaning records. Some of these measures had been put into place.
- There were some areas where the wooden door frames and shelving were damaged which meant they could not be adequately cleaned. Where this may present a risk it had been reported to the estates department for repair or replacement.
- The results of the hand hygiene audits were displayed on the harm free care boards on the wards. Those we saw had 100% compliance.
- Monthly hand hygiene audits were completed in all maternity areas. Between November 2014 and October 2015 all areas except ward M3 and the birthing centre consistently scored 100%. The lowest score on M3 had been 92% in March 2015 and the scores had improved since that date.
- We observed staff reminding patients and visitors to use the hand gel provided. This was available at the entrance to all wards and departments and by each patient's bed.
- We saw staff used personal protective equipment appropriately when required.
- There had been two cases of C.Diff in the maternity and gynaecology services between November 2014 and November 2015.
- We observed during an obstetric surgical procedure not all people present in the theatre wore Personal Protective Equipment (PPE) other than a plastic apron over their clothes. Whilst these people were not a part of the immediate operating team this could reduce the control of infection in the theatre. It does not meet with NICE quality standard (QS49) which states "people having surgery are cared for by an operating team that minimises the transfer of microorganisms during the procedure by following best practice in hand hygiene and theatre wear, and by not moving in and out of the operating area unnecessarily".

Environment and equipment

- There was a consultant led delivery suite with nine birthing rooms one of which had a birthing pool and nine single en-suite rooms. The midwifery led birth centre with four rooms three of which had birthing pools.

Maternity and gynaecology

- The maternity ward had 28 beds which could be used for either antenatal or post-natal patients. This meant there was flexibility in the use of the ward areas to accommodate the patients as required.
- The gynaecology ward had 10 inpatient beds and four assessment rooms. All gynaecology treatment and procedures were provided on this ward.
- There were two theatres for use by the obstetrics and gynaecology service. One was available and staffed for use 24 hours per day seven days per week. The second was used for elective gynaecology operations and as the emergency obstetric theatre if the first one was in use.
- The obstetric theatres were accessible from the delivery suite on the same floor.
- The guidelines on the adult resuscitation trolleys stated a sealed trolley should be checked weekly and an unsealed trolley daily. On the maternity ward the sealed trolley checklist record showed checks had been completed on the 29 November 2015, 14 December 2015 and 25 December 2015. On the gynaecology ward an unsealed trolley had been checked four times in January on the 20th of that month. This meant the checks had not been completed as required in the policy.
- The equipment for resuscitation of the new-born had not been checked daily in line with the trust's policy. Records showed some of this equipment had not been checked on fourteen days in one month.
- Records for daily checks on emergency equipment and provision of supplies had not been carried out on the delivery suite. The emergency equipment for the management of a post-partum haemorrhage had not been checked five times in January on the 21st of that month. The daily room checks which included the oxygen and suction supplies had not been completed on four consecutive days on the week of the inspection. This meant there was no assurance this equipment would work in an emergency.
- On the maternity ward the fridge patients used to store both formula milk and expressed breast milk was unlocked and in an unlocked room. The fridge had been locked however the key was misplaced. Tamper proof lids for the bottles had been made available however this had been recently introduced and not all midwives were aware. This meant milk for infant feeding was not securely stored in this area. On the delivery suite the fridge was in a locked room.
- Throughout the maternity wards and departments most of the wooden doors were wedged open. Some of these doors had notices on that they were fire doors and should be kept shut.
- Sufficient monitoring and clinical equipment was provided for example on the delivery suite there was a Cardiotogography monitor in every room.
- The equipment required for a home birth was accessible; including adequate stocks of frequently used supplies and clearly labelled emergency equipment.
- The equipment required to evacuate a patient from the birthing pool in an emergency was available.

Medicines

- Medicines on the maternity wards were securely stored, records were kept and systems for safe disposal were in place.
- We saw examples of safe practice in ensuring the patient took their medicine whilst the midwife observed; however we also saw one example of a midwife leaving medicine with a patient which they were aware would be left on a locker as the patient was leaving the area. Other patients and visitors were in this area.
- On the maternity ward there were two medicine administration trolleys with the computerised records whilst the care for patients was split into four teams. This meant staff had to wait for one of the trolleys to be free before they could administer medicines to the patients in their care. Patients told us pain relief was administered in a timely way.
- Controlled drugs were safely stored. The stock was checked by two midwives once every 24 hours and this check was recorded. We saw there was no documented name in the sample signature record for one of the midwives who had completed the drug check during the inspection. This meant that midwife may not be identified if this was required.
- A stock check of stored medicines was completed three times per week. This was carried out by the midwives on the wards and there was no frequent or regular monitoring by the pharmacy department.
- We were told the electronic system for ordering medicines meant there were no delays for patients as urgent medicines were quickly available from pharmacy.

- We found one medicine for use during home births was being stored outside of a fridge for one month longer than the manufacturer's recommendations. This was brought to the attention of the manager and immediate action was taken.
- The community midwives carried portable cylinders of medical gases in their cars. They were unclear if there was a risk assessment for this procedure.

Records

- There were clear plans of care for patients in medical and nursing records. These included antenatal assessments, referrals to other centres for specialist consultations, discussions with patients and families, discharge notes to secondary care providers and communication notes from community midwives.
- Risk assessments had been completed and reviewed for both maternity and gynaecology patients. These included those for venous thrombosis and to identify high risk patients such as those with a raised body mass index.
- Midwives records of the care provided during labour were clear and fully completed.
- There was an electronic system to record patient observations. The system had a series of features to alert staff to overdue observations or anomalies which required further actions. The maternity support assistants completed the observations and alerted a midwife if there was cause for concern.
- In the triage unit all calls were recorded. If the midwifery support assistant answered the call the midwife checked the advice given and countersigned the record. There were three calls recorded on the same sheet for each patient therefore a sequence of calls could be seen easily and increasing or repeated concerns were identified.
- The community midwives had some difficulties accessing electronic records in the GP surgeries due to lack of available computer equipment. A business case for the use of handheld devices had been submitted.
- There was duplication of some records in both the inpatient units and the community. This was due to the electronic patient record system not yet being fully implemented. Staff discussed how this was time consuming and there was a risk of important information being stored incorrectly or overlooked unless both systems were used.
- Records were securely stored and displays of information which could identify patients were designed to protect their confidentiality.

Safeguarding

- The CQC review of safeguarding in December 2014 found that there were shortfalls in the maternity services which could mean risks to pregnant women and new-born babies were not identified. Eight recommendations were made in relation to improvements in maternity services. An action plan had been developed in January 2015 and 50% of the actions were completed with the remainder in progress.
- 91% of staff in the children and families business group were up to date with level 2 safeguarding adults training and 94% with safeguarding children. In the last year staff were required to complete safeguarding in children training to level 3. In September 2015 80% of staff in the trust who required it had completed this training.
- Staff had received training in the recognition and reporting procedures for female genital mutilation (FGM). Midwives were aware of the trusts' policy and changes to reporting requirements which had come into force in October. Not all junior doctors were conversant with FGM legislation.
- The up to date procedures for reporting a safeguarding concern were readily available to staff in written format and on the intranet.
- There were procedures in place to safeguard a patient who did not attend for antenatal or postnatal appointments. This included prompts to identify these patients and steps to ensure their safety was checked.
- There was a lead midwife for safeguarding and six safeguarding champion midwives. Together this team provided additional support to some high risk patients on an individual basis, advised and supported staff that had patients with lower level safeguarding concerns on their caseload and offered training sessions.
- Safeguarding supervision had been introduced following the CQC review in December 2014. Midwives met with the safeguarding lead midwife at least four times annually and discussed the safeguarding children concerns. The safeguarding champions met monthly and discussed patients on their caseload. In September 2015 92% of safeguarding champions and 93% of community midwives had completed over four sessions, which was the trusts' target. However only 12% of hospital based midwives had completed this. We were

told the emphasis had been on those midwives working one to one with patients with complex needs. This meant not all midwives had the opportunity to formally discuss any issues or concerns around safeguarding.
- In the community there was a multi-disciplinary approach to safeguarding which included monthly meetings with the GP and health visitor to discuss any concerns and agree a plan of care. This had been a recommendation following the safeguarding review and in September 2015 70% of midwives had met with the appropriate health visitor.
- There was a system in place for staff to identify potential concerns for the safety of a patient or baby. This included prompts on the electronic patient record system for known substance misuse and previous mental health problems as well as easily identified paper records.
- Where a serious incident had occurred and the police were leading the investigation we saw the safeguarding lead midwife had carried out an internal review of the trusts' part in the patient's care. They had offered support and reflection opportunities to those involved and agreed actions to help prevent a similar incident. The safeguarding lead would review the practices further following completion of the formal investigation.
- If there were safeguarding concerns about a patient they would be seen for up to 28 days in the post-natal period. Visits to such patients would be limited to two midwives which enhanced the continuity of care and support.
- There was one midwife with a lead for safeguarding and the children's safeguarding team and perinatal mental health midwife deputised in her absence.
- The security system at the main entrance doors to the delivery suite and maternity ward were insufficient to protect the patients and babies from unwanted visitors. There was an intercom and video for entry and this was seen to be used appropriately by staff; however the doors could not be observed on the units and we saw visitors letting other unannounced people onto the wards. Staff reported this was a frequent occurrence. Any person could exit the ward unseen by pressing the door release button. This was brought to the attention of the trust at the time of the inspection.

Mandatory training

- 86.5% of staff in the child and families division were up to date with mandatory training.
- 52% of staff in the maternity and gynaecology services were not up to date with adult basic life support training. This meant staff had not updated their skills in this emergency care provision.
- 68% of staff in maternity services were up to date with neo-natal resuscitation. A change to the provision of this training to include it in the skills and drills had been discussed as way to improve compliance.
- 88% of the multidisciplinary team in the children and families business group were up to date with their skills and drills maternity specific training. Compliance was lowest amongst the midwives at 74% however managers were aware of this and had strategies in place for improvement.
- All staff received reminders via email if they were required to update any of their mandatory training.
- There was no designated practice development midwife although there was recognition from managers that this was required and one midwife had taken the lead.
- Junior doctors completed all the mandatory training prior to starting work at the trust.

Assessing and responding to patient risk

- There was a clear procedure in place to ensure all patients had their scans to screen for anomalies within the Fetal Anomaly Screening programme. The procedures had been changed in readiness for additional tests from 1 February 2016. If it was a high risk pregnancy additional scans would be offered.
- One of the rooms on the delivery suite was allocated as a room for patients with high dependency needs. Staff on this unit managed patients with some additional clinical needs, but not those who required respiratory support. Any patient thought to require transfer to the critical care unit would be seen on the maternity unit by the consultant and the decision made with the patient, midwifery staff and doctors. The trust did not provide information on the number of maternal transfers to the intensive care unit.
- There was no critical care outreach service; however a specialist critical care nurse would provide support on the maternity unit if required.
- A trust wide early warning score for assessing a deteriorating patient had been adapted for maternity. Doctors told us midwives and nurses escalated the care of patients appropriately. We saw this was accurately completed.

- Paediatric doctors attended emergency caesarean sections and other births if risks to the unborn baby had been identified. Midwives told us they were quick to respond when required and were part of care planning for high risk patients.
- Consultants and midwives discussed how transfers from the midwifery led birth centre to the consultant led delivery suite were carried out appropriately when required. There were no barriers between the two services. The intrapartum transfer rate from the midwifery led unit to the delivery suite was 31.4% in December 2015. There was no target that the trust were working towards on the information provided.
- Both community and inpatient midwives described good communication between the two teams. This included telephone conversations when patients attended triage or were admitted.
- We observed that not all steps in the safer surgical checklist were completed. The team members did not introduce themselves by name and role. This is essential to ensure every specialist required is present prior to the start of the procedure. The patient was identified by a staff member saying their name despite the patient being conscious they were not identified by confirming their own details. There were no maternity specific audits of the use of the safer surgery checklist. A trust wide audit which included some maternity checklists had been completed in December 2015 with a re-audit due in May 2016.
- The safer surgery checklist was present in records for patients who had received suturing for perineal tears in theatre.
- Acutely unwell babies were safely transferred to the neonatal unit. Transfers to the neonatal unit were 1.5% of babies under 37 weeks gestation in December 2015. The paediatric team would retrieve the baby from the maternity unit with the necessary equipment to ensure a safe transfer. They would obtain the information they needed in writing and verbally at this handover of care.

Midwifery staffing

- Midwifery staffing was described as a day to day "challenge" by the managers. 96 incidents had been reported between November 2014 and October 2015 about low staffing numbers which had affected patient care. These included "red flag" incidents in line with NICE safer staffing guidance. Managers discussed how the maintenance of safe midwifery staffing levels was on the risk register.
- Monthly staffing reports were viewed by the Head of midwifery. Safe staffing was monitored by 6 monthly reports to the Board co-ordinated by the deputy director of nursing and midwifery. Despite this staff at ward level were not aware of the outcome of these reviews.
- Birth rate plus acuity tool was used to assess the necessary staffing numbers for the maternity service. To assess the acuity on an ongoing basis the clinical lead midwife or the bleep holder for the service checked the roster for the service at 8am including any sickness then did a walk around the unit including the gynaecology ward, to ensure there were sufficient staff with the necessary skills and experience to meet the needs of the patients.
- In October 2015 19 midwifery day shifts and 12 night shifts were not filled with bank or agency staff. These shifts were then working with below the identified number of staff needed.
- The ratio of midwives to births was 1 to 30 which was worse than the England average of 1 to 27. However they had calculated this taking into account the work of the assistant practitioners.
- Midwives told us they achieved one to one care in labour. This information was documented on the data collected by the trust.
- Actions to improve the midwifery staffing included an additional five full time midwives on 12 month contracts to fill the maternity leave and long term sickness vacancies. Historically these had remained vacant.
- There was an escalation policy which included moving staff between areas, using non clinical staff to provide cover in a clinical area or asking midwives to come in from home. The community midwives were not used as part of the escalation procedure as there was recognition they needed to fulfil their visits to ensure patient care was not put at risk.
- In order to support the staff on the maternity units the band 7 midwives had an on call rota and there was always a supervisor of midwives on call. This meant staff could access support 24 hours per day if they required it.
- There was a supernumerary co-ordinator on the delivery suite every day. This met with safe staffing guidance.

Maternity and gynaecology

- The number of midwives in the midwifery led birth centre had been increased from two to three. Any community home births were attended by midwives from this centre.
- In response to activity on the maternity ward a twilight shift for maternity support assistants had been introduced. Managers had listened to staff concerns about their ability to deliver patient care at this time of day and responded accordingly.
- On the triage unit there was one midwife and one midwifery support worker. When this unit was busy the midwife could be occupied assessing a patient therefore the maternity assistant would provide advice to patients over the phone. To ensure this was appropriate the midwife checked the information provided.
- On the maternity ward, delivery suite and gynaecology ward all midwives and nurses received a verbal and written handover for all the patients on the ward. This included detailed information about their care, investigations, observations and plans for discharge.
- The birth rate plus acuity tool was used to allocate the caseload for the community midwives at one midwife to 96 patients. There were concerns from several midwives that the complexity of the patients' needs meant whilst this figure met with guidance in practice they had insufficient time to spend with patients who had risk factors associated with safeguarding, mental health or medical complexities.
- The community midwives had a rota which included working nights in the birth centre when they would also be the midwife on call for the community. There were two midwives and one midwifery assistant in the birth centre at night which meant this staffing was sufficient.
- Nurse staffing on the gynaecology ward met with the safer staffing guidelines. Information provided showed there had been two shifts between July and October 2015 when the ward had been one qualified nurse below the established requirement due to short term sickness.
- Where the activity had increased such as in the ultrasound department due to the AFFIRM study the case for additional staff was recognised. There was no confirmation this had been granted and the study had begun which had increased the activity in that department.
- The midwifery staff sickness rate was low. The highest was on the maternity ward at 5.88% for the previous 12 months.
- Assistant practitioners were employed to work alongside the midwives. They worked in both the community and inpatient setting and could complete a range of tasks to assist midwives. These included ante natal and post-natal checks for low risk patients, observations and being the second assistant at a birth.
- A team of operating theatre nurses was available 24 hours per day to assist in emergency obstetric operations. Midwives assisted in the anaesthetic recovery of patients.

Medical staffing

- Eleven consultants worked in the obstetrics and gynaecology service. Three of whom worked in obstetrics only and covered the on call as resident in the hospital. A consultant was on call 24 hours per day seven days per week with some of this time being resident in the hospital. They were present three nights per week and three weekends every eight weeks. The remaining gynaecology consultants covered the on call rota the rest of the time.
- During the day there was consultant presence between 8am and 8pm Monday to Friday. Between these hours they would attend the hospital to support a junior doctor if required.
- There was a registrar on call for the gynaecology ward out of hours with access to a consultant via the telephone.
- There was a shortage of consultants to attend the antenatal clinics. A senior registrar worked in these clinics which could cause delays if they needed to find a consultant in another part of the service to seek advice.
- The medical team had a handover of care from the night shift to the day shift at 08.30am on the delivery suite. All the medical team were present and the co-ordinator for the shift. All maternity inpatients were discussed and any expected admissions.
- At the morning handover information about any acute gynaecology admissions and post-operative patients was discussed.
- The consultant anaesthetist had a one to one discussion with the shift co-ordinator and the consultant obstetrician regarding any patients due to have anaesthetic. They also discussed the care for any prospective patients who may be attending the hospital.

Maternity and gynaecology

- A consultant anaesthetist was present Monday to Friday 8am to 6pm. Outside of these hours there was one on call. There was a speciality doctor available 24 hours per day who would request the support and assistance of the consultant on call if required.
- Junior doctors hours and on call rota was managed to ensure they did not work for long periods without a break.
- When junior doctors were on call they were supported by more senior doctors and told us this support was good and always available.

Major incident awareness and training

- There had been a table top exercise undertaken by department leads with support of the emergency preparedness team in 2015, however staff we spoke with had not received information about their role in a major incident. They were aware some training had taken place and that there was a focus group who led any work on this, but none we spoke with had been part of it.

Are maternity and gynaecology services effective?

Requires improvement

Maternity and gynaecology services required improvement in terms of being effective.

Policies and procedures were up to date, easily accessible and in line with National Institute for Clinical Excellence (NICE) and other guidelines such as the Royal College of Obstetrics and Gynaecology (RCOG). Audits took place to monitor the quality of the service provided; however there was a lack of clarity about how any areas for improvement identified were monitored.

Areas of potential concern we found had not been identified by the trust. Information gathered was not used to benchmark performance against other trusts or National targets. There was insufficient medical support for patients with diabetes.

There were around one quarter of midwives who were not up to date with their maternity specific training . The competence of midwives assisting in the operating theatre was not monitored and did not meet national guidance. However, there were good support mechanisms in place for junior doctors and student midwives.

Patients received timely pain relief. Systems were in place to offer good support for mothers who wished to breast feed. There were supportive systems for patients to have midwifery led care and home births. There were examples of effective multi-disciplinary working in obstetrics and gynaecology services. Access to services seven days per week included emergency gynaecology, early pregnancy and diagnostic services. Consent to care and treatment was obtained and recorded accurately including for termination of pregnancy.

Evidence-based care and treatment

- Policies, procedures and practices we observed were in line with NICE guidance. This included the induction of labour, intrapartum care and for caesarean sections.
- Changes and updates to guidelines were presented at the labour ward forum. Any areas of concern or changes required were discussed and the relevant person identified with a date for completion and re-presentation.
- A list of the guidelines which had been recently up dated was available for staff to ensure they were aware of changes.
- Staff in all areas knew how to access policies and procedures and they were available in both written form and on the intranet.
- Midwives collected data for audits and did receive feedback following completion of audits.
- Midwives could audit activities should they wish to assess practices for their effectiveness. An example of this was a high rate of non- attendance at the anaesthetic clinic for patients with a body mass index of 40 and over. They audited 100 sets of notes over a 12 month period and completed a survey of the patients. The result was a change to the referral proforma and development of a text reminder service. Re-audit within 12 months was planned.
- The provision of the midwifery led birth centre offered patients a choice of a more “normal” childbirth. Midwives attended the North West network for normality to share good practice and learn from others.

- The trust's endometriosis service was accredited by the British Society for Gynaecological endoscopy. Endometriosis is a common condition in which small pieces of the womb lining are found outside the womb.

Pain relief

- Pain relief was available in the triage unit and midwives could prescribe this under the midwives exemptions which meant patients who attended could have analgesia in a timely fashion.
- Patients on the gynaecology ward told us pain relief was available promptly when it was required. We saw staff assessed patients' pain verbally.
- Patient controlled analgesia (PCA) was offered to patients within risk assessment guidelines. This is any method of allowing a person in pain to administer their own pain relief. The infusion is programmable by the prescriber. The anaesthetist set up the pump to ensure the correct medicine was prescribed. It was popular with patients who could be more independent in their management of pain.
- The anaesthetist support meant a doctor was available to administer epidural pain relief within 30 minutes of request which met NICE guidance.
- Community midwives had access to pain relief including medical gases for home births.

Nutrition and hydration

- The trust had been awarded stage 3 Baby friendly accreditation, which was due for revalidation in 2017. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method.
- In July 2015 the trust had audited their service against the NICE standards for maternal and child nutrition and found themselves to be compliant.
- The rates of breastfeeding at delivery, on leaving the hospital and on discharge from maternity care were provided by the trust. However these were not included separately on the dashboard of maternity measures and no target was presented. Therefore it was not possible to understand if the rates were declining, improving or meeting the trust's target. The rates were monitored by the trust on the integrated performance report.
- There was an infant feeding team of four staff to support the infant feeding lead – midwife, health visitor, peer support co-ordinator and peer support worker. They had completed training as lactation consultants and worked on the maternity ward to assist and support new mothers to establish breast feeding. They worked closely with the peer support volunteers.
- There were 60 breast feeding peer support volunteers. They completed a nine week course before assisting and supporting other patients.
- All new mothers who chose to breast feed had a follow up telephone call within 48 hours of discharge to offer support if required. An appointment for a home visit would be arranged at this time if needed. Post-natal support for breast feeding was provided by assistant practitioners. They worked in both the hospital and community.
- Mothers who chose to bottle feed were also supported and given help and advice. Three types of infant formula milk were provided to offer a choice which patients could then continue on discharge.
- There was a patients' kitchen on each ward where patients and partners could make hot and cold drinks and snacks. A café was on the ground floor of the women's unit which provided hot and cold snacks. Meals were provided for patients who remained in hospital.
- Patients told us the food provided was sufficient in quantity and was good. Special diets were catered for and snacks were available between meals if required.
- There was a tongue tie clinic twice weekly on the post-natal ward. There was 190 referrals per month from community midwives and GPs. Specially trained midwives could perform a frenulotomy which is the removal of a small fold of tissue in the mouth which restricts infant feeding. This could be done immediately which negated the need to wait and increased the likelihood of successful breastfeeding.

Patient outcomes

- An audit of post-partum haemorrhages at the trust was completed in September 2014 and presented to the obstetrics and gynaecology meeting in May 2015. Recommendations for improvements to practice were made as some practices, such as the medicines used, the process for fluid replacement therapy and some documentation did not meet with NICE and RCOG guidance. These actions were implemented and

re-audit should have taken place in September 2015 to assess the improvements. No information as to whether the re-audit took place or results of it were provided by the trust.

- There had been 15 still births between April and December 2015. This represented 5.73 still births per 1000 births which was higher than the national average of 1 to 3 per 1000 births. There was no recognition of this and therefore no full investigations into the reasons for it, however SBAR was carried out and the trust was an early adopter of the Sabine project where the aim was to achieve a 50% reduction in still births. This information was collected on a monthly basis; however there was no target set.
- Since August 2015 the trust was taking part in the UK wide AFFIRM study. This meant patients with reduced fetal movements had a focussed care package including early interventions. The perceived outcome would be a reduction in still births however this had not been underway long enough for any changes to be seen.
- A target of 24% was set for caesarean sections. This measure had not been recorded for two months of the past 12 however the rate was only within this target for three of the 10 months recorded.
- There was currently no enhanced recovery pathway for patients who had a caesarean section. This was being developed by one of the obstetricians.
- Patients who had delivered by caesarean section previously could access information and support to have a vaginal delivery in subsequent pregnancies. A weekly clinic for vaginal birth following a caesarean section was run by a consultant and a midwife.
- The rate for third and fourth degree tears following instrumental delivery was 12.5% in September and October with the trusts target at 5%. There was no record of this being discussed in the minutes of the quality governance board during those months. The rate had since reduced and was below the target in December 2015.
- The home birth rate in the High Peak area of the service was 7% which is above the trusts' target.
- Maternal admissions to intensive care or re-admission rates were not recorded as part of the monthly data collection.
- Admission rates to the neonatal unit were recorded. This did not specify if the admission was expected or an emergency.
- All patients received at least three post-natal visits. To increase continuity of care the post-natal visit dates may be changed to ensure visits by a known midwife. These would remain within the NICE recommended guidelines.
- Between 85% and 90% of cancer treatment was provided laparoscopically. This meant patients had the required treatment without invasive procedures.

Competent staff

- 75% of midwives were up to date with appraisals with their line manager; however 100% were up to date with their annual review from their supervisor of midwives. This meant all midwives had had the opportunity to discuss their performance and development in the past 12 months.
- Midwives rotated between the maternity ward and the delivery suite to maintain their skills and competence. There was no formal pattern for this as midwives discussed the need for updating their skills during supervision when agreement would be reached about their rotation. They told us they were never required to carry out duties for which they were not competent and the co-ordinators allocated work according to their knowledge and experience.
- 53 midwives had completed training in new-born infant physical examination. This meant midwives could complete this examination and reduce delays in patients waiting for a paediatrician This also meant patients could be discharged home and community midwives could complete this examination. .
- 76% of midwives were up to date with the antenatal screening updates.
- Nurses on the gynaecology ward had completed specific training such as safe use of speculums and one nurse was completing training to carry out hysteroscopies.
- The lead gynaecology nurse had developed nurse led services at the trust and completed training in several gynaecological procedures in order to provide this service. She had received an honorary award as recognition for her work.
- The assistant practitioners were educated to foundation degree level. They also completed additional training as part of their induction to the trust. This included skills and drills in obstetric emergencies and mandatory training.

- The midwives preceptorship programme was currently for 12 to 18 months however this was due to increase to two years to be consistent with other trusts in the region.
- There was no practice development midwife in place. There was a midwife in post as an interim role and midwives told us they hoped this would become a permanent role.
- An annual diabetes study day took place with multi-disciplinary input and attendance. Staff attended every three years to update their knowledge.
- Diabetic emergencies such as hypoglycaemic episodes were included in the annual maternity skills and drills training.
- The midwives worked in the operating theatre to assist the anaesthetist in the recovery of a patient following a caesarean section. Most had completed training for this when they initially began working for the trust. This included acute illness management training; however there was no refresher training and no assessment of their competence to carry out this role. This does not meet with the Association of anaesthetists of Great Britain and Ireland Guidance 2013 which states "the person assisting the anaesthetist must be trained to a nationally recognised standard and must work regularly and frequently in the obstetric unit".
- All staff were included in the appraisal system and these were not approved by the supervisor unless mandatory training was up to date.
- Junior doctors completed three days induction training. This included two days of generic training and one specific to their speciality. For maternity services this included skills and drills training.
- Junior doctors had good support for learning and development. They had an educational supervisor and had time allocated for trust and regional training. They stated recognition of their training time being protected was good and a locum would be employed rather than a junior doctor miss their training.
- We saw appropriate involvement of the supervisors of midwives to support staff and discuss issues and concerns with patients. This included discussions when a patient wanted to give birth in the midwifery led unit but their risk assessment indicated they needed consultant led care.

Multidisciplinary working

- In the community midwives and health visitors were affiliated to GP practices and weekly meetings were held to discuss any issues or concerns about a patient. This meant risks to patients or babies were identified early and agreement about ongoing monitoring was reached.
- Midwife managers and consultants worked together to discuss issues and plan the development of the service. One example was the midwife manager of the antenatal clinics who attended the consultants meetings where actions were agreed to improve the provision of consultants at the clinics.
- Consultants told us they worked well with the midwives and there was good cooperation and communication. This included those who worked in theatres
- There were good transfer arrangements for babies from the delivery suite to the neonatal unit. A nurse and doctor from that unit went to delivery suite, had a verbal handover of the care and took any documentation with the baby to the neonatal unit.
- Weekly multi-disciplinary clinics for patients with diabetes took place. Dieticians and the diabetes lead midwife saw patients at these clinics. There should be a diabetes specialist consultant in attendance however due to a shortage of these doctors in the trust their support was often provided over the telephone. The risk of not having this input had been realised and there were plans to recruit to the vacant post. The midwife attended trust wide meetings with diabetes specialists from other services and there were plans to include a diabetes general nurse at these clinics.
- Sonographers had concerns they may not be able to meet the increased workload demands on ultrasound scans of one of the recently introduced research studies into fetal anomalies. They had the equipment to accommodate the increase, but not the staff. They felt they should have been more involved in the planning of this.
- Consultants in obstetrics and gynaecology had weekly protected time for multi-disciplinary meetings. These were attended by midwives, nurses and doctors from other specialisms.
- Nurses in the gynaecology services told us the doctors were very supportive of the expansion of the nurse led services. They provided the necessary medical input such as signing consent forms and worked collaboratively to make sure the patient's journey was efficient.

Maternity and gynaecology

Seven-day services

- The gynaecology assessment unit was open 24 hours per day and seven days per week. Referrals were taken from the emergency department, GPs and patients could self-refer to the unit.
- There was a maternity triage area which was open from 7.30am to 1.30am seven days per week. Between these hours the service was transferred to the birth centre. This meant patients had 24 hour access seven days per week to both telephone advice and physical assessment services.
- The antenatal day unit was open Monday to Friday 7.30am to 6pm and at weekends 9am to 1pm. This was for booked appointments for antenatal checks and advice such as blood pressure checks. This meant patients could access this service seven days per week.
- Patients who attended the early pregnancy unit could access a scan seven days per week.
- A tongue tie clinic took place on Sundays as a result of patient feedback and to ensure a timely response was available for babies with this condition.

Access to information

- There was a records management for the women's unit on site. Staff on the maternity units told us there were no problems with access to information, medical records were accessed quickly.
- Gynaecology staff reported the necessary information was usually available in the clinics. However since the list of attendees was provided on the same day as the clinic if there were alterations or late additions and records were not available this could cause a delay. We were told one patient had to have their procedure cancelled due to lack of records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- An audit of consent for obstetric surgical procedures was completed in September 2014. The findings were that the correct procedures were followed, the appropriate consent forms were used and documentation of risks and benefits was thorough and legible. Areas for improvement included better additional information being provided to the patient and the patient to print their name on the form.
- The five sets of patient notes we reviewed had consent forms accurately completed which were legible.
- We reviewed four sets of notes for patients having a termination of pregnancy. The necessary Department of health forms and consent to treatment were correctly completed and signed.
- Assessments of a young persons' competence to consent to a termination of pregnancy were completed following the Gillick competence guidelines.
- Staff understood their role and responsibilities within the mental capacity act. They had not experienced a need to instigate a Deprivation of Liberty Safeguard., but were aware when this may be required.
- The common assessment framework was used for patients with a learning disability. This would be carried out with the inclusion of an independent mental capacity advocate and the learning disability link nurse for the trust.
- Staff were aware of the need for best interest meetings when a patient lacked the mental capacity to make their own decisions. They discussed situations where this had been used.
- Examples were given when advocates had been used to ensure a patient with reduced mental capacity had the support they required.

Are maternity and gynaecology services caring?

Good

Maternity and gynaecology services were good in terms of caring.

Patients were complimentary about the attitudes of nurses, midwives and doctors. They told us they spoke to them in a respectful manner and protected their privacy and dignity. We observed staff to be polite, calm and friendly during interactions with patients. The results of the Friends and Family Test (FFT) and the 2015 CQC maternity survey showed the trust performed better than other trusts or the England average in some measures and equal in the others.

Patients and their partners were involved in their maternity care and families of patients on the gynaecology ward were welcomed and included if the patient wished. Choices were discussed such as opting for midwifery or consultant led

care and discussions took place if changes occurred which meant these options were no longer available. Emotional support was available for patients who had suffered trauma, a difficult period of care or bereavement.

Compassionate care

- Staff spoke about patients in a dignified, respectful and caring way when they were transferring information about their care.
- We saw there were curtains provided and in use around patients' beds and in treatment rooms to protect their privacy.
- We heard the midwives in the triage unit speaking to patients in a polite, friendly and professional manner. They offered advice and support and alternatives for patients to visit the unit if they remained concerned following the telephone discussion.
- Patients on the gynaecology ward told us staff were very caring and attentive, "nothing was too much for them" and they checked a patient's condition regularly.
- There was recognition when patients required additional support. An example was a patient who was receiving additional support with breast feeding and was remaining as an inpatient at their request to improve their confidence prior to leaving hospital.
- Theatre staff were seen to be calm, friendly and caring to patients who were having surgical procedures.
- Three patients we spoke with who lived outside of the usual catchment area for the hospital had chosen to use the services because the reputation was good.
- The trust performed better than the England average in the Friends and Family Test (FFT) for patients who would recommend post-natal care and care during birth (100% with a 47% response rate) in September 2015. There was a 17% response rate for community care where they were slightly below the England average for antenatal care and postnatal care.
- The trust scored better than other trusts for two areas out of 17 questions in the CQC maternity survey 2015. These were for partners being as involved as they wanted to and staff introducing themselves to patients. They scored the same as other trusts in the other indicators.

Understanding and involvement of patients and those close to them

- Patients in maternity services had been involved in their birthing plan. This was recorded and any changes due to risk assessments or other developments were discussed with the patient.
- On the maternity ward the partners of mothers could stay overnight should they wish. The behaviour required to ensure patients were not disturbed was discussed and monitored by the staff.
- Partners told us they had felt included in all stages of the pregnancy and birth and the staff had cared for them as well as the patient.
- The options for disposal of human remains following a termination of pregnancy were discussed with patients. The guidelines for sensitive disposal and offering choices for patients were followed.
- Should an anomaly be seen during an ultrasound scan the sonographer would discuss their initial findings with the patient and immediately seek a second opinion. This meant the patient did not leave the unit without having the information available as a result of the scan.
- On the gynaecology ward patients said visitors were welcomed to the ward and included in their care if they wished. An example was given of nurses assisting an older visitor to get to the ward due to lifts being out of order.

Emotional support

- Following a termination of pregnancy patients were signposted to counselling services and given written information for how to access these services.
- There was a quiet room on the antenatal clinic which was used to discuss bad news with a patient.
- The bereavement midwife supported patients through their bereavement by carrying out home visits and offering guidance through any following pregnancy.
- Information of available counselling services was provided to bereaved parents.
- Patients who had experience a traumatic birth were offered a debrief session with a midwife and consultant.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

Maternity and gynaecology services were good in terms of being responsive.

Services were planned to reduce the need for patients to travel long distances taking into account the large geographical spread of the area. The organisation of the service meant there was provision for quick triage of patients and transfer to the appropriate area in a timely way if they required midwifery care only; however patients needing assessment by a doctor could be required to wait as was also the case in the ante-natal clinics. The impact of this on patients had not been measured. Bed occupancy in maternity services was lower than the England average and effective escalation procedures were in place at busy times.

The nurse led gynaecology service meant patients could receive urgent care 24 hours per day seven days per week and have gynaecology procedures completed as an outpatient. Most of the targets for referral and treatment times for gynaecology patients were met; however the targets for the two week referral times for cancer patients were not being met. The reasons had been investigated and some were outside of the trusts' control. Actions had been taken to improve this. There was access to termination of pregnancy services within recommended timescales.

There were specialist midwives for patients with more complex social, emotional or health needs. The midwife for safeguarding was also the lead midwife for vulnerable adults which included substance abuse for example. These also included teenage pregnancy, diabetes and mental health. Most of these were part-time however which meant they could offer one to one support to a limited number of patients. Some concerns had also been recognised with the provision of perinatal mental health support and actions were being developed to manage this.

Service planning and delivery to meet the needs of local people

- Due to the large geographical spread of service provision a system was in place which reduced the need for a patient to attend hospital unnecessarily when in early labour. When a patient contacted maternity triage a community midwife would visit the patient at home and carry out an assessment rather than this being done in hospital if suitable.
- A "mobilisation" room had been set up as part of the triage unit. This provided a homely environment, with comfortable seating and a kitchenette area. Patients and their partners could remain in this room if they had attended triage, but their progression of labour meant they did not need to go on to the delivery suite and they did not wish to return home due to needing additional support or the distance of the journey. This provided a suitably comfortable setting for patients to remain on the unit as long as they wished. There was no time limit to their use of this room.
- There had been changes to the community midwifery teams to increase the continuity of care for women following their feedback. All the community midwives we spoke with told us the changes had improved patient care as continuity meant they could identify changes and risks more quickly as they built relationships with patients.
- The waiting areas in the antenatal clinic meant there was separation for the pregnant women and those who may be attending due to gynaecological problems.
- Attendance at the hospital throughout a pregnancy was made as easy as possible for patients. A car park pass for £10 could be obtained which lasted throughout a patient's pregnancy.
- Patients who attended the ward with concerns about their pregnancy were able to wait and be accommodated separately than other patients.

Access and flow

- The antenatal clinics in the hospital were organised so that patients could be seen by the midwife prior to being seen by the consultant. This reduced the waiting time for patients.
- The antenatal clinic manager and the maternity records manager worked together to ensure patients did not have their appointments cancelled. They managed the appointments within a risk assessment traffic light system so that high risk patients were offered quick appointments.
- The triage service was operational seven days per week for 24 hours per day. Staff said patients who attended were usually seen by a midwife within 30 minutes. If they needed to be seen by a doctor there could be

delays and there was no agreed timeframe within which a patient should be seen. No doctor was allocated to this area therefore they would need to wait until one was free from delivery suite. The delays were not recorded and had not been audited.

- Patients contacted the triage unit to obtain results of blood tests and this resulted in a high number of calls with 58 general enquires being made in one day plus additional ante-natal calls. This meant the midwife was occupied on the telephone and patients waited to be seen. The waiting times had not been audited.
- The midwives on the triage unit could request a scan which meant the patient did not need to wait to be seen by a doctor.
- Midwives could assess and discharge patients in the ante-natal day unit without waiting for medical consultation unless there was a clinical need for their input. This meant patients could be discharged in a timely manner.
- Bed occupancy was lower than the England average in the past 12 months. This had risen to its highest during July to September 2015 at 59%.
- The Trust used the Greater Manchester escalation policy in times of increased activity or staff shortage. Following prior agreement with neighbouring units women were deflected to their nearest unit when they contacted maternity triage. The ambulance service continued to bring women in an emergency unless the full escalation policy was activated and they would redirect to the nearest unit. At all times if women presented to the unit without prior arrangement they would be seen.
- The unit had been on divert 10 times between January 2014 and June 2015. There was a threshold for diverting patients from the maternity unit based on the potential risk to patients. When the unit was busy continual risk assessment would take place and following discussion with the senior management team for the trust the divert procedure would be used as per the locally agreed policy. The timescale would be a short as possible and in November 2015, which was the last time it was used, the unit was closed for three hours and one lady was diverted. A review of the situation takes place the following day for lessons learned to be shared.
- It was more common for this trust to accept patients who were diverted from other maternity units in the region.
- A gynaecology assessment unit was open 24 hours per day seven days per week. This meant patients had access to specialist doctors and nurses in a dedicated environment. They could be referred directly by their GP or via the emergency department to reduce the time they had to wait to see their specialist.
- Nurse led gynaecology services had been introduced which reduced the waiting times for patients. These included hysteroscopy, endometriosis and a urodynamic service. Where possible procedures were completed on an outpatient basis. Sixteen hysteroscopies could be completed per day and two colposcopy clinics would run simultaneously. This provided a quicker service with less clinical risk to patients and with timely histology results.
- A specialist nurse oncologist completed excisions as an outpatient procedure which meant patients could have a consultation and their procedure on the same day.
- The referral to treatment times for the two week cancer wait for gynaecology patients had been within the trusts' target 0f 95% for three months between April and October 2015 and was 91.8% in October 2015. The reason for this was patients declining the first appointment offered. Actions taken to address this included additional clinics and completing a capacity and demand profile to examine the best longer term option.
- The referral to treatment times for non-urgent outpatient gynaecology appointments were within the targets.
- In September 2015 three gynaecology operations had been cancelled due to lack of time and one due to lack of equipment. All four had been rebooked within 28 days.
- The trust was meeting the six week target for completing gynaecology diagnostic tests.
- The termination of pregnancy unit for those patients requiring this service for social reasons provided a rapid response which took place four days per week. This meant local patients could access this within timescales which met current guidance.
- There were plans to reduce the length of stay for patients having a termination of pregnancy. The medicines used were being reviewed in light of practice at other centres which had reduced the number of hours a patient needed to be in hospital.

Meeting people's individual needs

- Face to face translation services were used in preference to a telephone system as staff said it was better for the patients to understand especially when discussing clinical issues. There were no delays in accessing this service when it was required.
- Following a termination of pregnancy patients were offered contraception which the lead nurse could prescribe. This meant the patient did not leave the hospital without this information being provided and offered.
- Leaflets could be obtained in a variety of languages and we were told there was a simple system for ordering these.
- The ultrasound scanning department provided an ad hoc on call service should this be required out of hours. This included attendance for confirmation of an intra-uterine death if that was required.
- There was a perinatal mental health midwife employed part time. They held a small caseload of patients with known mental health problems, held specialist antenatal clinics and supported other midwives who had patients with mental health problems on their caseload.
- The mental health specialist midwife held outpatient clinics with a mental health nurse and a consultant.
- The safeguarding lead midwife had identified shortfalls in the awareness and support for patients with mental health problems. Actions had been taken to improve the assessment processes, increase communication between health professionals and train staff in mental health awareness. However community midwives had a high number of patients who required additional support on their caseloads which led to decreased time to manage individual needs.
- The Maternity Services Liaison Committee (MSLC) had held a meeting on 14 January 2016 to discuss perinatal mental health in Stockport. They had raised concerns about poor provision of perinatal mental health services in 2014 and results of the Picker survey 2015 had shown some areas which required improvement. As a result an action plan had been developed to improve these services. Plans included a review of the community services to improve the continuity of midwife support, training in mental health for all midwives and the development of information packs for patients.
- There was one part time midwife dedicated to the care of pregnant teenagers. They had around 25 under 18 year old patients on their caseload and provided specific care and support to this group of patients. They had completed training for this specialist role and liaised with the family nurse partnership, attending weekly meetings.
- The lead midwife for safeguarding was also the lead midwife for vulnerable groups which included substance misuse. Midwives could make direct referrals to the specialist general team for support.
- Specific plans of care were discussed for patients with a learning disability. This included the involvement of social services, the learning disability nurse, one consultant obstetrician and an advocate. Prior to one patient being admitted, to give birth, plans had included viewing accommodation, meeting staff and strategies for reducing anxiety such as playing music in theatre.
- Diabetes link midwives had been appointed on the maternity wards. They had completed training and had support from the part time specialist diabetes midwife to offer support and advice to diabetic patients in a timely way.
- A weekly “preparation for a health pregnancy” clinic was held for patients with a body mass index (BMI) of 35 and over. The benefits of weight loss were discussed and advice given. If a patient had a BMI of over 40 they were assessed by a consultant anaesthetist. This is in line with NICE guidance.
- The screening midwife provided counselling to the patients if an abnormality was detected on a scan. They then arranged timely termination of that pregnancy if that was the patient’s choice, without them having to make repeated visits or have a prolonged wait.
- A room for use by bereaved patients and their families was provided in an area away from the general bustle of the delivery suite. This had been made into a homely environment with a bedroom and separate sitting area with kitchen facilities. Patients and their families could remain in this room for as long as they needed following a stillbirth or neonatal death.

Learning from complaints and concerns

- The manager of the antenatal clinic stated they had not received a formal complaint for over two years.
- We observed that when a patient wished to complain about an aspect of their care the ward manager saw them immediately, listened to the issues, offered an apology and a solution for their ongoing care and support. They completed an incident report, provided written information to the patient about the complaint

procedure and escalated the concern to the head of midwifery. The managers told us they would always try to resolve a complaint as soon as possible if it was appropriate.

- Managers on the women's unit shared issues and learning from complaints in the labour ward forums, ward meetings and community midwife meetings.
- Complaints were discussed at the monthly meetings of the quality and governance board for the child and families division. It was agreed at the meeting in November 2015 that the clinical director would see all complaints which would mean they had an oversight of any themes or repeated issues.

Are maternity and gynaecology services well-led?

Requires improvement

Maternity and gynaecology services required improvement in terms of being well led.

Multi-disciplinary staff in both the obstetrics and gynaecology services were aware of the vision for the trust and resulting uncertainty about the development of their service. They had been included in discussions and felt they were being kept aware of potential changes. Staff spoke positively about the leadership in their immediate area and in the wider trust. They described supportive leaders and opportunities for themselves to develop leadership skills.

However, the governance system had not identified several clinical issues we found. There was a lack of monitoring of performance against trust or national targets and therefore a lack of understanding of where improvements were necessary. There was no date of entry or review for risks on the divisional risk register. Not all risks that had been identified were recorded.

Staff of all grades described an open culture with a sense of pride in the service they provided. Mechanisms were in place for engagement with users of the service. Staff told us they felt included, their views were sought and valued; however some formal opportunities for engagement were not effective in practice. Staff were able to make changes to services where improvements had been identified.

Vision and strategy for this service

- Managers, midwives, doctors and nurses knew the strategy for the service and had attended meetings held to discuss the possibilities for the future. Although it was not clear at the time of the inspection what this meant for maternity and gynaecology services they felt informed and included.
- Senior managers discussed that they knew there would be changes to the maternity services within the five year strategy; however they felt positive about the changes because they were involved and included in decision making.

Governance, risk management and quality measurement

- Maternity and gynaecology services were part of the child and family business group. There was an interim director in that business group who was also the head of children's services. There was a head of midwifery, a clinical midwifery manager and a lead nurse for gynaecology. There was some lack of clarity about the future management roles within the leadership team.
- Outcomes for patients in the maternity service were not measured in a way that resulted in this information being used to inform practices. Information on outcomes for patients such as the number of post-partum haemorrhages over 1500mls, still births, instrumental delivery rates and third and fourth degree tears was collected on a monthly basis. These were either the number of incidences or a percentage of births. Whilst some had targets others did not and staff including managers were not aware of this information being used to monitor the quality of the service.
- Some outcome measures were reported at trust level which included key performance indicators for the National Screening Committee. Quarterly performance reports were submitted to the Trust Quality and Governance Board.
- Doctors and midwives were not aware of how well the service performed against National, regional or trust targets. One consultant told us they were not aware of any statistics which related to risk or general data such as post-partum haemorrhage rates or perinatal mortality. They said learning was shared from specific incidents verbally at the weekly meetings, however they

saw no minutes from governance meetings. The minutes of various divisional quality and governance meetings we reviewed did not record discussions about performance towards targets or comparative data.

- Monthly multi-disciplinary governance and risk meetings for the children and families business group took place. Items discussed included serious incidents, complaints and risk assessments. Actions required were noted and discussed at the following meeting. Despite this some risks and outcome measures were not part of these discussions therefore actions for those were not identified.
- Information from these meetings was discussed at the trusts quality and governance committee meetings.
- The risk register and risk assessments were discussed at the monthly meetings. There was a risk summary report which contained brief description of the risk, the person responsible for the management of it, the initial, current and target rating and the review date. The date of entry on the register was not documented neither were any subsequent reviews only the next date. This meant it was not possible to understand if risks were managed in a timely manner.
- Individual risk assessments were completed for each risk on the register. These contained a descriptor and actions required to manage that risk. If staff identified risks they could escalate to their line manager outside of the monthly meeting process and a risk assessment would be completed and presented at the meeting.
- Some risks which had been identified and escalated were not on the risk register. This included the lack of availability of basic life support training which resulted in staff not having up to date knowledge and skills.

Leadership of service

- Nurses and midwives felt supported by their leaders, they worked alongside them and were approachable.
- The management structure was described as “not hierarchical” but one where people could discuss ideas and were listened to and included.
- Midwives and nurses were able to attend leadership courses in order to develop their career. Opportunities to work in leadership roles were made available for band 6 midwives and above. Other leadership development opportunities included coaching courses and financial support for degree courses.
- The band 7 midwives could be autonomous in their decision making about how to manage their area of the service. They could make changes without the need to go through overly complex systems.

Culture within the service

- Staff of all grades told us they could discuss any issues or concerns they had with their immediate manager and the trust management if that was appropriate.
- We were told there was a feeling of trust amongst the managers and the staff which resulted in staff believing communication was open and honest.
- There were positive descriptions of the teamwork within the service which resulted in “good morale”, a “sense of pride” in the service and a feeling of “community”.
- Consultants, junior doctors, midwives and nurses described a “good morale” in the service where they felt included.

Public engagement

- There was a maternity services liaison committee that met monthly. The meetings were well attended by patient representatives, specialist midwives, community health workers and representatives from local voluntary groups. These meetings were recorded and where issues had been raised we saw actions had been taken and updates were provided.
- Antenatal and post-natal support groups for patients with diabetes had been set up at the request of patients with this condition. These were peer led groups with support from the specialist midwife and took place at regular intervals throughout the pregnancy and after birth. These had been developed as a result of patient request which showed their ideas were respected.
- The band 7 midwives wore red uniforms to denote they were in charge. This was as the result of patient feedback that they could not identify the most senior person.
- Midwives attended local events such as providing a stall with information about breast feeding in the local shopping centre. They took such opportunities to engage with the local population.

Staff engagement

- Staff we spoke with were happy working at the trust; many had chosen to do so even though it was not the nearest hospital for them. They told us they felt included in the day to day running of the service and could contribute professionally.
- The gynaecology services staff had presented a case for their future working and development within the proposed changes in the trust. This had been well accepted by the trust and they felt they had been listened to.
- Staff of all grades said they knew the trust board were accessible, they saw communications from them in the form of emails and key messages on the intranet.
- Although the monthly labour ward forum meetings were open to all staff to attend minutes for the past three months showed between eight and ten people attended all of who were managers. Midwives said they knew they could attend but usually did not have the time. They could read the minutes which were available on the wards and units and the expectation was that managers shared the information. This was an opportunity for staff engagement which was not effective in practice.

Innovation, improvement and sustainability

- In order to improve the service midwives and nurses attended regional and national forums, meetings and networks. They were encouraged to share ideas and bring those back to their own units which may improve practice.
- There were examples when staff had been encouraged and supported to change practices and develop services. This included nurse led gynaecology services and some aspects of community midwifery.
- Some areas of practice had been identified as needing improvements and actions had been completed to make the necessary changes. Staff felt where changes were needed there was a willingness to make sure they happened to make services for patients better. However we did find some aspects of the service where the need for improvement had not been identified.

Services for children and young people

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

Information about the service

Stockport NHS Foundation Trust neonatal and children and young people's service is predominantly based at Stepping Hill Hospital. A four-bedded respite facility is provided at Swanbourne Gardens (reported under the Children and Young People's Community Service).

At Stepping Hill Hospital, the trust provides a 17- cot neonatal unit based on the ground floor of the Women's unit. The neonatal unit is a designated level two unit (local neonatal unit). These units provide special care and high dependency care and a restricted number of intensive care cots (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit.

The neonatal unit has a link tertiary unitat St Mary's hospital in Manchester. Within the unit, there are 13 special care cots, two HDU cots and two ICU cots. There are four additional transitional care bedrooms. The neonatal unit operates as part of a regional neonatal managed clinical network to ensure best outcomes for babies.

Most other services for children and young people are provided in the Tree House Unit. The ground floor of this unit is for children's outpatients clinics, although some children are seen in other outpatient areas, for example Ear, Nose and Throat clinics, audiology, outpatients B and in radiology. The first floor of the unit is split into three inpatient areas (Acorn, Brambles and Rainforest) and a paediatric assessment unit (Mulberry ward). The second floor is office areas, which include children's community and Children's Adolescent Mental Health Services (CAMHS) (provided by Pennine Acute) offices.

Acorn ward consists of ten individual rooms accessed from a main corridor; Brambles ward is made up of three four bedded bays (one of the bays is dedicated to adolescent patients); Rainforest is an eight bedded ward and has two cubicles. There are two high dependency beds in a separate high dependency room. Mulberry ward consists of four-day case beds and eight assessment beds. In the Tree house unit there is a playroom, a schoolroom and facilities for parents and relatives. Outside is a purpose built play area that is appropriately equipped for children of a range of ages.

Children's surgery is performed from the Tree house unit. From July 2014 to June 2015, there were 4806 admissions to services for children and young people. 88% of these admissions were emergency admissions, 6% were day case admissions and 6% were elective admissions. General Practitioners have access to telephone advice from a paediatrician and have access to a same-day second opinion by direct referral to the assessment unit. GPs can make telephone referrals into paediatrician's clinic appointments at short notice. This promotes management of children at home. Parents or carers are able to stay with their children 24 hours a day. The paediatric unit works with Greater Manchester Network to promote better outcomes for children and young people.

As part of our inspection from 19 to 22 January, we visited inpatient and outpatient areas, paediatric A&E, paediatric surgery services, the paediatric assessment area and

neonatal unit. We spoke with a range of staff providing care and treatment in children and young people's services including: 20 nurses, two trainee doctors, one consultant, four health care assistants, two play specialists, a domestic, a teacher and senior managers.

We talked with eight parents and four patients on the ward areas. We observed patient care, talked with carers and reviewed thirteen patients' records of personal care and treatment.

We reviewed comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

We judged that though providing a good service overall, services for Children and Young people at Stepping Hill hospital were outstanding in terms of being caring and required improvement in terms of being safe.

The service provided an integrated approach to acute and community services, both services operating from the Tree house unit. This approach ensured that children were seen by the same group of staff in hospital and the community. Family centred care was the prevailing philosophy in children and young people's services. Children were involved with and positioned at the centre of their care. We found a positive culture where incident reporting and learning was embedded and used by staff. There was strong clinical and managerial leadership within the units and at business group level. There was an effective governance structure in place, which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.

Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect. Waiting areas in children's outpatients offered outstanding play facilities and equipment. There was a transition clinic for young people with diabetes to support their move from children's to adult services.

However, though overall we rated the service as good there were some issues especially in the safe domain that required improvement. Nurse staffing on the paediatric unit was not in line with the RCN guidance on safe staffing (2013). The trust did not have a band six staff member on 39.8% shifts from 14 December to 13 January. In a further six shifts the trust did not a band six staff member on for half of the shifts. From 14 December 2015 to 13 January 2016, the trust did not ensure there was a nursing staff member with Advanced Paediatric Life Support (APLS) on 12 of 93 shifts. From 14 December 2015 to 13 January 2016, the trust did not ensure there was a nursing staff member with HDU training on 14 of 93 shifts. Whilst there have not been any patient safety incidents as a result of this, it is recommended by the

Services for children and young people

Royal College of Nursing that the trust should have at least one APLS trained staff member on each nursing shift along with a staff member who is band six or above.

The security system that was in place on the neonatal unit and paediatric unit used an intercom system for visitors entering the ward and a swipe card system for staff. However, for exiting the ward, there was a push button allowing visitors to leave without being supervised. This meant there was a risk that children could leave the paediatric ward unsupervised and raised a concern in relation to child abduction.

During our unannounced inspection on the paediatric assessment unit, staff medications were stored within a cupboard with patient medication. On examination of the cupboard, codeine phosphate belonging to the trust was found in with staff's own medications. This gave us concern that trust medications may be being taken for staff members[FA1]' personal use. Additionally this medication should have been securely stored. We told the sister on the ward about this at the time of inspection.

Drugs requiring storage below certain temperatures were stored in fridges and most checks were in place to monitor fridge temperatures. On the paediatric unit, not all entries were complete on one of the fridges. This issue was discussed with the ward manager who escalated this to the safety huddle meeting. On our unannounced inspection, the high-dependency unit fridge was running with a high temperature (15 degrees C) and had not been checked that day. This meant medications may not have been as effective. We told the ward staff about this.

Are services for children and young people safe?

Requires improvement

Overall, in terms of safety, we judged that the neonatal and paediatric services at Stepping Hill Hospital required improvement.

- We reviewed nurse staffing in the Tree House unit from 14 December 2015 to 13 January 2016 considering the requirements set out in the Royal College of Nursing (RCN) Guidance on Staffing (2013). The service did not staff the in-patient areas in line with the guidance because it did not have a senior nurse, above band five, on 37 of 93 shifts (39.8%).In a further six shifts the service did not have a band six staff member on for half of the duration of the shifts. Most of these shifts were at night time.
- In terms of staffing ratios, based on bed occupancy at midnight, the service did not meet RCN guidance recommendations for safe staffing on 13 out of 31 shifts (41.9%). The nurse to patient ratios varied between 1:1.5 – 1:7.4.
- The service did not ensure there was a nursing staff member with APLS on 12 of 93 shifts (12.9%). The service did not ensure there was a nursing staff member with HDU training on 14 of 93 shifts (15%) which is against Paediatric Intensive Care Society recommendations (2010). On three of the shifts there was no staff member that was APLS or HDU trained.
- Whilst there have not been any patient safety incidents as a result of this, it is recommended by the RCN that the trust should have at least one APLS trained staff member on each nursing shift along with a supernumerary staff member who is band six or above.
- From November 2014 to November 2015 in paediatrics there were 15 incidents reported where the ward had been closed to admissions due to staffing shortages. The ward was closed to GP referrals on five other occasions. Of the incidents reported, on three occasions staff reported they felt the ward was unsafe.
- However, most staff members we spoke to felt that patients were safe at all times as the staff were familiar

with the escalation policy for deteriorating children and knew how to obtain further assistance from within the trust. There were no patient safety incidents recorded because of lack of staff.

- We reviewed the staffing within the neonatal unit. There was no senior nurse on each shift who has no clinical commitment managing day-to-day management of nursing care (a super-numerary shift co-ordinator). However, there were no safety incidents reported because of this issue. All staff members we spoke to felt patients were safe at all times because the staff were familiar with the escalation policy for deteriorating babies and knew how to obtain assistance from within the trust but also from North West Transport Service (NWTS).
- At the time of our inspection we were concerned about the door exit systems to the neonatal and paediatric units. To exit both units there were push buttons. In neonatal the entrance to the unit did not have anyone positioned close to it so 'tailgating' could occur or indeed people could be let onto the unit without staff being aware. This meant strangers could enter the unit and there was a risk of child abduction. In paediatrics no staff were close to the exit out of hours. We escalated these issues to the trust at the time of our inspection and they took immediate action.
- The trust monitored incidents and had processes for feeding back to staff so lessons could be learnt. We saw evidence that changes were made following learning from these incidents.

Incidents[FA1]

- Throughout the service there was a positive safety culture in relation to the reporting and learning from incidents. All staff we spoke with were familiar with the trust's electronic reporting system. They knew how to report incidents and who to escalate concerns too.
- Incidents from the neonatal unit were shared with the maternity service via the labour team forum to facilitate learning.
- Some incidents were automatically reportable such as babies with low temperatures when they were received onto the neonatal unit.
- The trust had reported three serious incidents between October 2014 and November 2015. Two of these incidents had been investigated and lessons learnt shared, the third was in the process of being investigated at the time of our inspection.
- When a serious incident occurred in the paediatric and neonatal units there was a debrief within 24 to 48 hours to discuss any immediate concerns and appoint a lead to investigate. An immediate assessment was undertaken considering the situation, background, analysis and recommendations (SBAR). Pending the full investigation this was shared to ensure any immediate recommendations were implemented.
- All staff we spoke to confirmed they received feedback following reporting incidents. We saw evidence of a range of methods sharing key learning from incidents. These included emails to all staff, lessons learnt were displayed on governance boards, documented team meeting minutes highlighted learning (staff members signed to confirm they had read these) and daily safety huddle meetings included discussion of any current issues.
- The trust reported that no never events had occurred within the last twelve months.
- Mortality meetings were held in the form of Joint Perinatal Mortality Meetings and critical reviews for any deaths involving children. The paediatric, neonatal and maternity services met on a quarterly basis to discuss relevant cases to ensure a multi-disciplinary approach to review and learning. Junior Doctors were also encouraged to attend.
- The trust did not use the patient safety thermometer. However, they monitored and recorded: the frequency of pressure ulcers; urinary tract infections; completion of risk assessments; recording of necessary observations; provision of safe and adequate pain relief; prevention of infection; family involvement in the care and privacy and dignity. The paediatric unit has not had a pressure ulcer since 4 December 2013. [FA2]The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood duty of candour and we saw evidence that the duty of candour regulation had been applied correctly.

Cleanliness, infection control and hygiene

- The trust reported that no incidents of Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile) had occurred within services within the last twelve months.

- Staff practised hand hygiene by using alcohol gel and gloves. In September 2015, the trust undertook an audit of the ward areas. On Rainforest and Mulberry wards, the overall compliance rate was 83.7%. On Brambles ward, the overall compliance rate was 81.4%. Cleaning needs were highlighted, staff were requested to use the temporary closure device on sharps bins and it was highlighted that the public should be made aware of infection prevention strategies. These issues were addressed in an action plan. On our inspection, we found the temporary closure devices were in use and that the cleaning needs had been addressed.
- The areas we inspected were visibly clean and tidy. Infection prevention posters were on display at the time of our inspection.
- The trust audited hand hygiene in all service areas in December 2015. The neonatal unit and paediatric unit were both 100% compliant.
- The neonatal unit had an infection prevention audit on 27 October 2015. Following this, a detailed action plan was drawn up identifying ten areas for improvement. Actions were all completed during October and November 2015. A re-audit was undertaken in January 2016 and the unit was found to be fully compliant with the trust's infection prevention criteria. During our inspection, we found that all the issues identified had been addressed.
- Toys in the play area appeared to be clean and fit for purpose. They were regularly cleaned after use on Acorn ward. Other toys were periodically cleaned. However, there was no written record to show the frequency of cleaning.
- We observed meal times and saw that the children were encouraged to wash their hands before eating.
- On neonatal the unit had won a trust award for no infection in a line for 2 ½ years.
- In children's outpatients, toys were cleaned weekly, but there was also a 'dirty toy box' where parents were asked to place toys after use to allow for additional cleaning.
- In children's outpatients, the cystic fibrosis team cohorted patients into groups who were seen on different days to prevent the spread of infection in this particularly vulnerable group.

Environment and equipment

- The security system that was in place on the neonatal unit and paediatric unit used an intercom system for visitors entering the ward and a swipe card system for staff. However, for exiting the ward, there was a push button allowing visitors to leave without being supervised. This meant there was a risk that children could leave the paediatric ward unsupervised and also raised a concern in relation to child abduction. We escalated this issue to the trust.
- We observed staff using clinical equipment competently on the neonatal unit and paediatric unit.
- There was a separate laundry within the neonatal unit to ensure clothing was washed appropriately.
- The neonatal milk room was locked. On one occasion during our inspection, the door had not been shut properly. A reminder sign was promptly placed on the door and we did not find it unlocked at any other point.
- On the paediatric ward, the milk equipment was in a staff only room. The door had a lock on it but this was not locked. We raised this issue with the ward manager who stated they had never had a problem with anyone other than staff entering the room as the room displayed staff only signs. She advised she would look into it further. On our unannounced inspection this was checked and found to be locked
- The wards used 'I am clean' stickers on equipment which were dated. All equipment we looked at was visibly clean and complete.
- Equipment was portable appliance tested (PAT).
- The trust had ISO 9001:2008 accreditation for the quality management system for asset management, maintenance and the repair of medical equipment.

Medicines

- Throughout our unannounced inspection on the paediatric assessment unit, staff medications were stored within a cupboard with children's medication. On examination of the cupboard, codeine phosphate belonging to the trust was found in with staff's own medications. This gave us concern that trust medications may be being taken for staff members' personal use. This was reported to the ward sister at the time of the inspection.
- Drugs requiring storage below certain temperatures were stored in fridges and most checks were in place to monitor fridge temperatures. On the paediatric unit, not all entries were complete for one of the fridges. This issue was discussed with the ward manager who escalated this to the safety huddle meeting. On our unannounced inspection, the high-dependency unit

fridge was found to running with a high temperature (15 degrees C) and had not been checked that day. This meant medications may not have been effective. This was reported to the ward sister at the time of the inspection.
- The service had a designated pharmacist.
- We checked the drugs audits on the neonatal unit and the paediatric unit and they were all fully completed confirming that all drugs were in date.
- Instructions were written on whiteboards to ensure staff could calculate the dosage of emergency medicine for children based on their weight.
- As the children's unit is not on the same electronic system as A&E, the ward had developed a system to print off patients' electronic records to help prevent medications being missed/given twice.
- The resuscitation trolleys were fully equipped and regular checks were evidenced to have occurred.
- The trust has a central intravenous additive system (CIVAS). They have recently introduced 'buffered saline' so that Benzylpenicillin can be made up and kept in the fridge for up to five days. This is in line with best practice.

Records

- We reviewed 10 sets of records on the paediatric unit and three sets of records on the neonatal unit.
- All records evidenced the name and grade of the doctor/ nurse reviewing the patient.
- All records evidenced that a consultant had seen the patient within twelve hours of admission. Appropriate care plans were in place and there was evidence of a daily ward round with appropriate reviews by senior clinicians.
- Appropriate action was taken when the PEWS (patient early warning score) indicated it was needed.
- In two out of four cases there was evidence of an antibiotic review.
- All notes were dated and signed. Discharge letters were promptly completed in all cases. Where appropriate, discharge-planning meetings had occurred.
- Neonatal notes were appropriately completed and reviewed.
- The paediatric unit are moving onto an electronic system for their patient records on 8 February 2016.
- Whilst reviewing patient records the scanning system proved challenging as some records were scanned upside down, chronology was difficult to follow and associated charts within the records were difficult to locate.
- Children had core care plans within their nursing records.
- On the neonatal unit babies had different charts to reflect their level of acuity.

Safeguarding

- The risk register identified an issue where documents were not scanned into live records in relation to safeguarding and clinical correspondence. This meant there was a potential delay in staff being aware of recent patient activity/safeguarding information. There was a delay of approximately three months before records were scanned into the system. The paediatric team identified this risk. They had taken appropriate action to mitigate this risk. This included ensuring all staff were aware of the issue and that records were kept within the Tree house Unit until they were scanned.
- We found that the service very rarely used agency staff. All staff we spoke with were aware of the delay with scanning and where they could locate records.
- The service had also put forward a business case to recruit a band two member of staff to scan paediatrics' records so this issue did not recur. The service was recruiting to this post at the time of our inspection.
- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.
- Relevant policies and procedures were available for staff to refer to.
- The trust had named safeguarding leads who worked closely with the staff on the wards.
- On the paediatric ward all nurses and administrative staff were level three trained. This is in accordance with best practice.
- National guidance from the intercollegiate document 'Safeguarding children and young people: roles and competences for health care staff' states that all "clinical staff working with children, young people and/or their parents/carers" should be level three trained.

- The electronic record system in children's outpatients immediately alerted staff to any safeguarding concerns. There was a system in place to use in paper notes which included a specified coloured sheet to identify that there were safeguarding concerns about a child.
- One radiographer had received level three training, along with two occupational therapists and five physiotherapists.
- We asked the trust to confirm the number of medical staff that had received level three safeguarding training. The trust advised us that 85% of substantive consultants had received level three training. The trust told us that the two paediatricians who require level three refresher training would be booked onto the level three 3 training being held in 2016.
- We asked the trust about other medical staff. The trust advised us that one of the 15 honorary medical staff members had received level three safeguarding training and 10 out of 15 honorary medical staff members had received level two training.
- We discussed this issue with the trust who referred us to The Royal College of Paediatricians and Child Health (RCPH) roles and competencies for health staff. This states that level 3 training is required for 'paediatricians' but doesn't specify state what grade. The trust's named doctor for safeguarding children advised that the RCPH guidance for "paediatricians in training' and their general competencies requires level 2 safeguarding for st1-3 and level 3 for st4 and above. This includes the staff highlighted as honorary. We advised the trust that best practice was outline in the intercollegiate document and the trust advised us that they will be implementing an induction plan around safeguarding training for all newly appointed honorary staff to improve the compliance of training. The trust advised that this will be monitored by the Named Doctor for Safeguarding Children and the Clinical Director.

Mandatory training

- The trust used an electronic staff records system, which sent email reminders to staff to notify them that their mandatory training would expire shortly.
- During our visit, the neonatal unit displayed a sign, which indicated that 97% of their staff were up to date with their mandatory training. They had a new member of staff, who had been on the unit for three weeks at the time of our inspection.
- We reviewed the actual number of staff that had worked on the neonatal unit who had neonatal life support training from 14 December 2015 – 13 January 2016. This showed that 85.2% of staff were NLS trained. There was always at least one NLS trained staff member on each shift.
- On the paediatric unit, the ward manager informed us that all nursing staff were up to date with their mandatory training. The trust information indicated that 86.52% of all staff were up to date with their mandatory training, which is above the trust's own target of 85%.

Assessing and responding to patient risk

- A paediatric early warning score (PEWS) system was in use. This tool supported early identification of children at risk of deterioration.
- There was a specific ward for surgery patients staffed by a dedicated team of nurses.
- In the records we reviewed, deteriorating patients were managed in accordance with the trust's escalation of deteriorating child policy.
- The children's unit had frequent admissions from young-people who self-harm. Staff said the support from the CAMHS team was very good. Once patients were medically stable, they were seen within 24 hours. Each weekend there was a CAMHS staff member working one of the two days. Staff had access to 24-hour CAMHS advice should it be required.
- In the event that a paediatric patient deteriorated, the trust had a clear deterioration policy that included a quick reference chart. A paediatric consultant would manage the patient within theatre and stabilise them with support from the anaesthetist team. The team would contact the North West and North Wales Paediatric Transport Service (NWTS) who could include on the call any range of specialists. A transfer would be requested. NWTS specialise in the transfer of critically ill children from District General Hospitals to one of the two Paediatric Intensive Care Units (PICUs) within the North West and North Wales area.
- In neonatal the team manage deteriorating babies in line with guidance from NWTS. They requested a transfer from NWTS. The baby would be transported to the nearest level three unit with cot space.

Nursing staffing

- On the Tree House unit we reviewed staffing from 14 December 2015 to 13 January 2016. The trust did not

staff in-patient areas in line with RCN Guidance on Staffing (2013). The trust did not have a supernumerary senior nurse, above band five, on 37 of 93 shifts (39.8%). In a further six shifts the trust did not have a senior nursing staff member on for half of the duration of the shifts.

- We reviewed staffing ratios for compliance with RCN guidance over the same period. Based on bed occupancy at midnight, the trust did not meet RCN guidance recommendations for safe staffing on 13 out of 31 shifts (41.9%). The service did not record patient numbers per shift and did not use an acuity tool. Senior nursing staff told us that they avoided putting an absolute staff ratio to children number on any area of the children's ward excluding HDU. Nursing staff undertook a nursing assessment to review patient acuity, turnover of patients, skills and patient mix. Staff told us these reviews were undertaken hourly during winter but this information was not recorded. We did not see evidence of this during our inspection.
- At the time of our inspection service leads told us that most of the band fives in post were experienced. Staff told us that senior nurses could be contacted at home if they needed advice. If there was a staff shortage, nursing staff followed an escalation policy. We saw evidence that nursing staff followed the escalation policy. If nursing staff were concerned about a patient's medical condition, they liaised with medical staff.
- Over the same time period the service did not ensure there was a nursing staff member with APLS on 12 of 93 shifts (12.9%). The service did not ensure there was a nursing staff member with HDU training on 14 of 93 shifts (15%). On three of the shifts there was no staff member that was APLS or HDU trained.
- Whilst there have not been any patient safety incidents as a result of this, it is recommended by the RCN that the trust should have at least one APLS trained staff member on each nursing shift along with a supernumerary staff member who is band six or above.
- We saw no records that evidenced how skills mix had been considered for each shift to ensure there was APLS and HDU trained staff on duty. Nursing leads told us that for HDU cover most staff (except newly qualified nurses) could be identified to go into HDU. We found that nurses did not have to be HDU trained prior to being rotad to go in HDU. This is against PICS guidance (2010, 72). We escalated all our concerns regarding nurse staffing at the time of our inspection for immediate action.
- Senior nursing staff told us they helped with nursing care and the community nursing team were contacted to assist with staffing on the ward and to help manage patients at home when appropriate.
- The trust is part of the paediatric network and had agreements in place to transfer children out of A&E if ward staff felt they were unable to provide safe care. The trust provided evidence of occasions when this had occurred.
- Service leads told us that in accordance with their escalation policy, the hot week and on call consultant would be informed about any patients requiring HDU care and they were provided with management plans. Trust staff explained they felt supported by medical staff when managing HDU patients. There were no reported incidents of patient harm due to staff shortages/skills.
- On the neonatal unit, nurse staffing was compliant with BAPM standards in terms of skills mix and ratios. However, nursing staff were not supported by a supernumerary co-ordinator in line with BAPM guidance for staffing.
- Nursing staff on the ward were supported by ward clerk cover from 7am – 7pm seven days a week.
- The paediatric and neonatal units did not use an acuity tool.
- Handovers on both wards took place twice a day. Both handovers we attended were comprehensive and thorough.
- There were no nursing staff vacancies at the time of our inspection. Use of agency staff was minimal: the ward manager could recall one use of agency staff throughout the entire winter period.
- Nursing staff were given the option to rotate around the different paediatric areas including the assessment unit and community nursing.
- The staff sickness level is 6.7%, slightly higher than the trust's target of 4%.

Medical staffing

- Out of hours consultant cover is on the trust risk register for both the neonatal and paediatric units. The trust had two consultant vacancies resulting in current consultants undertaking more out of hours cover. The clinical lead advised that two new consultants had been recruited and new starters should be in post by April 2016 to alleviate this problem.

Services for children and young people

- The trust does not have a separate consultant rota for the neonatal unit because the number of deliveries at the Trust is below 4000 per year. However, they do have consultants with an interest in neonatology.
- The trust stated that they complied with BAPM guidelines for medical staff cover and we saw evidence of this.
- Medical handover meetings were well led and clearly identified children and young people at risk of deterioration. The trust has a deteriorating child policy, which includes a requirement to contact Consultants in defined circumstances. We saw evidence that this had previously occurred.

Major incident awareness and training

- Staff were aware of their responsibilities in the event of a major incident.
- Major incident plans had been developed and business continuity plans were in place.
- These were available on the Trust internet for staff to refer to.

Are services for children and young people effective?

Good

Overall, in terms of being effective, we judged that the neonatal and paediatric services at Stepping Hill Hospital were good.

- Evidence based care and treatment was delivered in line with best practice guidelines.
- The children's service were trialling 'Ready, Steady, Go', an initiative to assist patients to gain the skills and knowledge to manage their conditions. This initiative was introduced to help patients feel prepared for their transition to adult services but also to enable patients to understand when they needed to seek medical assistance.
- The Paediatric Diabetes Audit 2013/14 showed that the trust had performed better than the national average for the percentage of children and young people achieving the NICE recommended HbA1C target.
- The trust had recently launched an inter-agency 'focus group' to look at improvements in CAMHS provision for 16-18 year olds. We found that a child's or their parent's consent was appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving their consent as appropriate and those we spoke to had a good understanding of their conditions and how they could help themselves improve.
- There was good multidisciplinary team working in the service including between the acute hospital team and those that worked in the community. This enabled the service to deliver a holistic approach encouraging management of children's conditions at home where possible.
- Staff said they felt they were given opportunities to develop e.g. in the neonatal unit the nurses were encouraged to work at specialised units to enable them to develop skills in looking after babies with more complex medical needs.
- Appraisal rates for nursing and medical staff were 100% for medical and nursing staff on the paediatric and neonatal units.

Evidence-based care and treatment

- The trust had its own microsite from which policies and procedures could be accessed.
- We witnessed the use of a daily safety briefing, which were given to all staff. This covered patient issues, staffing, safeguarding, environment, equipment, medicines, policies and safety alerts.
- National patient safety alerts were communicated to staff through daily briefings. Staff were provided updates if and when guidance was reviewed or practice changed.
- The neonatal unit were working towards Bliss accreditation. In recognition of their efforts Bliss devised an 'improving care' aware which the trust were given.
- The service followed NICE guidance and on occasion were demonstrating best practice prior to the guidance being developed e.g. for diabetes the service had developed continuous glucose monitoring 12 months before NICE guidance on this had been published.
- On the trust's intranet there were clinical treatment standard operating procedures which were in line with NICE guidance e.g. diarrhoea and vomiting and nasogastric feeding. The policies were reviewed every two years but were also reviewed in response to audits and amendments to NICE guidance.

Pain relief

- The neonatal unit had developed their own pain management policy for management of pain in neonates.
- Children's pain was assessed using recognised pain assessment scales.
- Pain relief included using age-appropriate methods and both analgesic and non-analgesic interventions. The play therapists used distraction techniques where possible.
- Neonates were offered small amounts of oral sucrose to reduce procedural pain.
- The hospital had a pain management team but also had a link to the Children's Hospital pain team at Manchester Royal Infirmary.
- Three different pain management charts were used on the paediatric unit to address the needs of different ages of children.

Nutrition and hydration

- Children and young people were offered a choice of meals that were age appropriate and supported individual needs such as specific diets. A review of meals available to children was being undertaken at the time of our inspection.
- The service employed two paediatric dieticians who supported diet requirements on the ward.
- The service has the level three Baby Friendly Initiative rating from Unicef in recognition of the support provided to encourage mothers to breast feed.
- Breast pumps were loaned to women to encourage feeding of breast milk.
- Mothers told us they received support to breast feed when they visited the neonatal unit and understood why they were encouraged to do so.

Patient outcomes

- The Paediatric Diabetes Audit 2013/14 showed that the trust had performed better than the national average for the percentage of children and young people achieving the NICE recommended HbA1C target <58mmol/mol.
- The emergency re-admission rate within two days was lower than the England average for non-elective paediatric admissions for both <1 and 1-17 yrs.
- The rate of multiple admissions within 12 months for asthma and epilepsy is higher than the England average. The asthma readmission rate was 19.7% against an average of 16.8%. Specialist nurses see asthma patients to help patients manage their condition and to keep them out of hospital. However, no audits had been undertaken to assess the impact of this facility. For epilepsy, the readmission rate was 32.1% against an average of 27.8%.
- The number of infants having breast milk at discharge from the neonatal unit was 80%, above the national average of 70%.
- In the National Neonatal Audit Programme published in 2014 a standard is that 98-100% of babies to have their temperature taken within an hour of birth. At Stepping Hill 100% had their temperature taking within an hour of birth,
- In the National Neonatal Audit Programme published in 2014 a standard is that 85% of mothers receive any dose of antenatal steroids. The service achieved this standard by giving steroids to 85% of mothers. The neonatal unit improved benchmarking in December 2015 by changing it to 'Best Practice Standards' to encourage sharing of good practice. The nursing education leads from the Greater Manchester Network meet monthly to discuss most recent evidence basis and set the standards for care.
- Recent areas covered include respiratory care and bereavement. Once a standard is set, the nursing education leads and a junior nursing staff member audit the unit's performance against the standard and create an action plan with the unit manager. At a later date, either six or twelve months, a peer review is undertaken by a nursing education lead from another trust within the network. It is planned that feedback will be provided and acted upon. Prior to implementation of the new procedure, for the last three years educational leads attended a bi-monthly meeting within the Greater Manchester network to share best practice to improve patient outcomes.
- In the National Neonatal Audit 2014, an issue was identified that 58% of parents were not documented as being seen by a consultant within 24 hours of their baby's admission. In 14% of admissions, it was recorded that parents had not met a consultant. The team reviewed this issue and felt that discussions were happening but they were not being documented. The team had an action plan in place to address this and were awaiting the most recent data set at the time of our inspection.
- For retinopathy screening 100% of eligible babies should receive ROP screening within the time windows

first screening recommended in guidelines. The service achieved this in 89% of cases. The trust created an action plan to address this and provisionally reported to us at the time of our inspection that the latest figures had improved to 97% of cases.

Competent staff

- Staff told us that they felt they had the correct training to meet the needs of patients and that there was no restriction on them accessing appropriate training. However, when we reviewed the staffing it was evident that staff were working within the HDU without completion of APLS training and/or the HDU degree module. Staff did have paediatric life support (PLS) training and/or acute illness management (AIMS) training.
- On the neonatal unit, staff were offered the opportunity to complete further training in level three units and complete funded neonatal courses.
- Staff were able to request specific training they felt was relevant to them. The paediatric matron said that the team had had CAMHS training and been offered experience based training from the local coroner on processes, roles and responsibilities in coroners court cases.
- Trust data showed that 100% of staff had received an appraisal in the last 12 months.
- The CAMHS team offered their input to the children's unit and staff said they felt it was beneficial that the CAMHS staff were based in the Tree house unit.
- In paediatric outpatients 100% of appraisals had been completed as at December 2015

Multidisciplinary working

- Nurses, doctors and members of the CAMHS team informed us that multi-disciplinary working within children and young people's services was good.
- 'Ready, Steady, Go' has been introduced in the children's service to help people manage their own medical conditions but also to support transition to adult services. The trust had transition clinics in place in diabetes and cystic fibrosis.
- Links between the local community healthcare team and the hospital were good ensuring effective follow up by paediatric community nurses as necessary following discharge. The acute and community teams saw themselves as a whole team, which enabled the trust to offer a holistic approach to their patients.
- In all relevant cases, there was evidence of multi-disciplinary involvement in a patient's care within patients' records.
- In children's outpatients, there was a multi-disciplinary cystic fibrosis clinic that included professionals from the Royal Manchester Children's Hospital and AHPs. There was a diabetes clinic that included members of the multi-disciplinary team (MDT), and other specialists from Royal Manchester Children's Hospital visited to carry out neurology and nephrology clinics.

Seven-day services

- The CAMHS team offered a six-day service with telephone advice available on the other day.
- A consultant was available seven days a week with cover out of hours provided by an on-call consultant.
- There was a consultant and registrar ward round every day. Medical patients were reviewed on a daily basis and this frequency could be increased depending on their clinical needs. Surgical patients were generally reviewed daily, dependent on their clinical needs. Orthopaedic patients had plans recorded within their notes as to the frequency they needed a consultant review. This was condition dependent for example a patient on the ward had a fractured femur and he was reviewed weekly by the consultant and every other day by the registrar.
- Play therapy services were offered seven days a week.
- Specialist nurses were available seven days a week. They accepted direct referrals from GPs for children over three months old.
- In children's outpatients, appointments were only offered Monday to Friday 8am until 6pm. There were no evening clinics. Staff told us that patients or their families have requested appointments out of hours but they have been unable to accommodate this.
- There were three radiographers on site 24 hours a day, seven days a week to provide plain film x-rays, mobile x-rays, CT scans and theatre imaging. One of these radiographers was trained in reporting CT head scans. Non-obstetric ultrasound was offered at weekends provided by a private organisation, supported by in-house radiology assistants.

Access to information

- Trust policies and procedures were available to staff via the trust's internet.

Services for children and young people

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- 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
- The intranet provided clear guidelines for medical conditions, safeguarding and clinical treatment standard operating procedures.
- The trust had information leaflets available about different conditions and provided parents and carers with information packs when patients were admitted to the ward areas.

Consent

- Staff were aware of consent procedures in place for children and young people.
- We found that a child's or their parent's consent was appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving their consent as appropriate. Parents confirmed this.
- The play specialist informed us that there was widespread use of diversional play materials to help with consent procedures.

Are services for children and young people caring?

Outstanding ☆

We found that services for Children and Young people at Stepping Hill hospital were outstanding in terms of being caring.

- The service provided an integrated approach to acute and community services, both services operating from the Tree house unit. This approach ensured that children were seen by the same group of staff in hospital and the community.
- Family centred care was the prevailing philosophy in children and young people's services. Children were involved with and positioned at the centre of their care.
- Within the service there was a strong, visible person-centred culture from all staff members in the team.
- Staff were fully committed to working in partnership with patients and their families to ensure their needs were addressed. Where possible, children were managed within their own home environment, which enabled them to remain in a familiar environment with their loved ones.
- We were informed by members of the nursing staff that a key aim of the unit was to develop patient's understanding of their conditions and how to manage them. The 'Ready, Steady, Go' strategy helped staff to work towards this aim.
- Parents were consistently enthusiastic about the care their children received from the medical and nursing staff. We observed positive, compassionate interactions between staff and patients and families.
- Staff took time to listen to patients and made a point of speaking to parents/patients when they entered the ward areas even when they were not addressing their nursing needs.
- In the friends and family survey the trust scored above national average for its parent facilities.

Compassionate care

- Parents we interviewed were enthusiastic about the care their children received from the medical and nursing staff. We observed positive, compassionate interactions between staff and patients and families.
- Parents told us that doctors and nurses informed their children and gained their consent or ascent before undertaking procedures. We witnessed nurses engaging positively with children and making good eye contact with them during any explanations. The nurses were empathetic with the children they cared for and showed a genuine interest in each child as an individual.
- We observed a nurse interacting with a child discussing a potential new planet that had been discovered. The nurse had spent her own time finding out about the planet because she knew the patient had a keen interest in space. This enabled her to deliver more personalised care.
- Staff told us about long-term patients who had stayed on the unit for a number of weeks. One child had been on the ward for nearly a year. Staff had decorated his bedroom window with a rainbow and arc. Staff enabled his parents to continue to work during the day by making extra provision for him. The staff regularly sang to him, took him out to the play area and ensured he

received additional care during the day. On one occasion, shortly before the patient died, his family were going to take him to the beach. Sadly, the patient deteriorated before he could go to the beach, so staff recreated the beach within his room so his family could have that experience.
- Staff regularly fundraised for the unit and recently raised money for the 3D television in the ceiling in the treatment room to help distract children during procedures.
- Staff supported patients who were repeat visitors to the unit by arranging for PAT testing for patients' electronic equipment so they could have their own personal things around them. When patients were coming back into the unit the staff decorated the patients' rooms with personalised welcome back posters and banners.
- Parents told us they were confident with the care and support they were given on the neonatal unit.
- In children's outpatients, parents told us that staff were excellent at providing information about care and treatment. Some parents told us they travelled further than necessary to receive care from children's outpatients at Stepping Hill.
- Individual needs were understood and considered when delivering services including dementia, learning disabilities, bariatric patients and the needs of children. In neonatal staff recognised that parents were feeling overwhelmed with lots of information and did not always get the opportunity to acknowledge or understand the progress steps their baby was making towards being discharged. They created a 'baby passport' with progress steps in them which also outlined which information leaflet to collect for each next step. Parents were positive about this.
- Senior staff valued the relationships that their teams had with the patients that they cared for. We observed service leaders and senior nursing staff taking the time to talk to patients, engaging with staff and helping on the ward. Staff within the department clearly cared for each other as well as the patients.

Understanding and involvement of patients and those close to them

- Parents were consistently positive about staff and felt included in the care that was being provided to their children.
- Parents told us that they were kept well informed about their children's medical condition and that the doctors and nurses gave explanations in simple terms that they understood. One child told us how he was very clear about the things he needed to do to help himself get better.
- Parents told us that they valued that when staff came into the ward area that they would take the time to speak to the patients and parents even when they weren't addressing their nursing needs.
- Children requiring surgery were offered pre-assessment visits prior to admission that helped familiarise them with the environment.
- We observed that parents were allowed to accompany their children to the anaesthetic room and the recovery area post-surgery.
- Mothers in the neonatal were encouraged to express their breast milk and they received positive breast feeding support from the nurses and breast feeding advisers.
- The neonatal unit had a range of leaflets that complemented their 'baby passport'. The leaflets were staged depending on the baby's development. Parents were prompted via the 'baby passport' and nursing staff to know which information leaflets were relevant to them at a particular point in time.
- Staff were aware how to contact interpreters and of the services that were available.
- Children using the service were encouraged to use their voice through child friendly surveys. The results were acted upon so repeat visitors could see their opinions were valued.

Emotional support

- All staff we spoke to within children's and young people's services were complementary about the emotional support offered to young people via the CAMHS team.
- Staff worked hard to provide parents with emotional support. In one case parents had hoped to take their child to the beach. Sadly he deteriorated and was unable to go. Staff went the extra mile to overcome this barrier and recreated the beach within his room so that the family could have the experience with their child.
- In neonatal staff recognised that parents were feeling overwhelmed with lots of information and did not always get the opportunity to acknowledge or understand the progress steps their baby was making

towards being discharged. They created a 'baby passport' with progress steps in them which also outlined which information leaflet to collect for each next step. Parents were positive about this.

Are services for children and young people responsive?

Good

Services for Children and Young people at Stepping Hill hospital were good in terms of being responsive.

- The service was planned and delivered to be flexible enough to meet the individual needs of children, young people and their families. Services were tailor made with the specific needs and preferences of children and young people in mind.
- Children with complex needs were appropriately cared for with an effort being made to manage children within the community, a key benefit of the integrated care model. A further benefit of the integrated care model was that children with complex needs were seen by the same team of health professionals both at home and within the hospital.
- The trust had a team of specialist children's nurses that supported children with long-term conditions such as asthma and epilepsy. This team also took direct referrals from GPs to ensure quicker access to services.
- All children had free TV and young people had access to age related distractions such as games consoles. The play specialist had access to appropriate diversional materials.
- A teacher visited the unit to help provide continued education for those children who were well enough.
- The service referral to treatment indicator averaged 96.5% from April 2015 – January 2016.

However;

- The trust did not attend (DNA) rate for outpatients at Stepping Hill Hospital was 8%. In paediatrics this figure included community clinic appointments as the clinics were combined clinics where acute and community patients were seen.

Service planning and delivery to meet the needs of local people

- The paediatric service provided wrap around care by the same group of professionals. This meant that children were seen by the same group of staff and facilitated more patients being seen within the community so children could remain in their preferred place of care.
- Clinics that were run were mixed clinics between community and acute patients.
- There was an open access policy in the Tree house unit for children with long-term or life limiting illnesses. This meant that children and young people could spend much of their time in the company of loved ones.
- The service participated in the national neonatal parent survey completed October 2013 – September 2014 (published March 2015) and devised a service action plan in response to the results. The service was developed by the neonatal unit who created a plan to improve communication between parents and doctors. They created a system on the unit and using doctors handover notes to identify parents that need updating by a doctor. A system has also been set up to ensure that babies born before 30 weeks gestation are routinely given a two-year review.
- The diabetes clinic in children's outpatients ran a transition clinic specifically for older children who would soon be transitioning to adult services.
- The service also had good transition arrangements for cystic fibrosis[AP1].
- At the time of our inspection, the trust had play specialists working from 7:30am until 6:30pm during the week and from 9am until 3pm at weekends. The play specialists were well regarded by their peers.
- Children had core care plans within their nursing records which ensured their play needs had been considered and that play provision was provided by the play therapists.

Access and flow

- Children with established health pathways had direct access to the children's ward.
- GPs could telephone the Tree house unit to seek advice from a paediatrician. Paediatricians offered short notice clinic appointments if a patient's needs could be better met in clinic rather than during a hospital admission.
- The paediatric assessment unit was open from 9:30am until 10pm. Outside these times patients were assessed on the ward.

Services for children and young people

- In children's outpatients, parents told us that access the appointments was good and that there was flexibility to change appointment times when needed to fit around work and school commitments.
- The trust did not attend (DNA) rate for outpatients at Stepping Hill Hospital was 8%. In paediatrics this figure included community clinic appointments as the clinics were combined clinics where acute and community patients were seen.
- The service referral to treatment indicator averaged 96.5% from April 2015 – January 2016.

Meeting people's individual needs

- Children with complex needs were appropriately cared for with a real effort being made to manage children within the community, a key benefit of the integrated care model.
- Translation services were available as required.
- All children's beds had free TV and young people had access to age related distractions such as games consoles. The play specialist had access to appropriate diversional materials.
- The play specialists had access to equipment for children with learning disabilities.
- Mealtimes took place within a classroom, which had mixed height chairs and desks along with highchairs.
- Waiting areas in children's outpatients offered outstanding play facilities and equipment.
- The neonatal unit was split into an area for level three cots and two other areas for level two and level one cots. All cots had monitoring equipment that was linked to the nurses' station. All ward areas had special sound detecting equipment (the ear – listening ear) that could be adjusted to meet individual patients needs so that the environment promoted appropriate levels of noise for the babies' development.
- On the paediatric unit wards comprised of individual rooms and four-bedded bays. Nursing staff confirmed that teenagers had their own four-bedded bay. This was mixed-sex.
- There was a well-equipped breast-feeding room on the neonatal unit equipped with suitable equipment to facilitate the use of breast pumps away from the ward area. Mums had the choice whether to express by the cot-side or within the designated room.
- The neonatal unit had a quiet room for parents and had a playroom for patients' siblings.
- Books were provided for parents so they could read to their babies.
- The ward had a treatment room, which was fitted with a 3D television in the ceiling to help distract children. Play specialists also helped anxious children.
- The parents' room was well equipped and visibly clean and tidy.
- The service worked with local commissioners to develop standardised information for parents so that GPs, school nurses and the hospital all provided standardised information for parents.
- The service provided a podcast for asthma uses demonstrating how to use inhalers appropriately.
- If a patient was at the end of their life, with support from the end of life team, ward staff arranged for patients to have the chance to go to Francis House (a local hospice) or to receive end of life care in their preferred setting.
- The children's outpatient area in Tree Tops Unit was very child friendly. There were lots of toys and activities for children to play with. There were specific activities for older children and teenagers and a designated 'teenage den'. There was a well-designed outdoor play area. Parents and children were very complimentary about the environment and activities provided.
- There was a dedicated bereavement office in the trust. The paediatric ward had good links with local hospices.
- The neonatal unit ward manager explained that they had access to a psychologist service for parents.
- We saw evidence of how the team had taken appropriate safeguarding action for a parent whilst also providing access to appropriate support for him whilst his child was in hospital.
- The paediatric unit staff had worked with a local group of parents to create specific packs to support parents whose children were having specific procedures. They created a parental peer support group to offer parents contact details for other parents whose child had gone through a similar procedure. For example staff created a DVD self-help pack for children having spiker surgery.
- The neonatal unit had parent rooms. Parents on both the neonatal and children's wards also had their own lounges and access to facilities for making tea and coffee. Parents advised that breakfast was also provided for them. Breastfeeding mothers were offered meals throughout their baby's stay. Basic parent accommodation and sleeping arrangements were available in the children's ward. However, separate

bathroom facilities were not available; parents had to use the same facilities as children. Parents rated their facilities above national average in the Friends and Family Test.
- The service had undertaken surveys from service users and used the outcome to improve the service it provides e.g., food audit and teenagers' room
- In the teenagers bay there were mixed sex patients.

Learning from complaints and concerns

- Parents were well signposted to Patient Advice and Liaison Service.
- The children and young people service leads had reflected on their complaints service and have taken the decision to try to resolve complaints sooner by meeting with complainants were possible.
- Staff were encouraged to address concerns that were expressed to them.
- Learning from complaints was communicated to all staff and shared on notice boards. All staff we spoke with could inform us of recent learning because of complaints made.

Are services for children and young people well-led?

Good

Services for Children and Young people at Stepping Hill hospital were good in terms of being well led.

- There was a tangible commitment to patient centred care among all members of the multi-disciplinary team. Service organisation enabled the team to truly holistically endeavour to meet the needs of the patients.
- Staff felt supported by their line managers who were visible and accessible.
- All staff we spoke with explained that they felt they could approach anyone at any level within the trust.
- Staff had a clear vision of how to develop and improve the service. There were clear aspirations to develop the service, but were also clear examples within the service of areas that were being developed e.g. CAMHS provision within the paediatric unit.
- Staff recognised that there were increased pressures around meeting the needs of 16-18 year old adolescents with multi-faceted mental health needs that require an admission to hospital. A ward matron set up a focus group with other agencies to review CAMHS provision for 16-19 year olds and look at ways to plan better provision across the area.
- The risk register identified key risks and identified areas of improvement. The service leaders had steps in place to mitigate risks within the department in the meantime, but longer-term solutions from the trust were not always visible.

Vision and strategy for this service

- Staff understood the organisation vision and values. Staff had a clear vision of how to develop and improve the service. However, the service had been informed very recently that there would be major changes to how the service was going to be delivered at Trust level. Senior managers had begun to approach key members of staff to support future service planning. In the interim the plan was to carry on with the current service delivery model until more strategic changes had been decided.

Governance, risk management and quality measurement

- On the paediatric unit, a staff member specifically had a governance role within the department. This ensured there was more consistency with complaints investigation and ensured that staff members were kept appraised of developments and new/amended initiatives.
- On the neonatal unit, each sister had responsibility for different governance areas and specific quality measurements.
- The business group held monthly meetings where governance, risk management and quality measurements were discussed. There was also a quality board where issues were discussed and escalated as required.

Leadership of service

- Staff felt supported by their line managers who were visible and accessible.
- There was an open and approachable culture within the department.
- The Chief Executive held a monthly forum that staff can book into if they wish to discuss anything with her.

- Monthly meetings took place between medical and nursing leads to ensure issues were shared and developments were discussed.
- The working relationship between nursing and medical leads reflected a clear commitment to teamwork, collaborative working and the provision of holistic care for patients.

Culture within the service

- There was a tangible commitment to patient centred care among all members of the multi-disciplinary team.
- Senior leaders valued staff within their teams and described them as 'an amazing, responsive and flexible group' of people.
- The nurses on the unit all felt that the children's wards were friendly places with a good atmosphere. All staff said that they would be happy for their families to be cared for on the ward.
- Nursing staff sickness rates in children's outpatients was low at 0.76% for the period January 2015 to December 2015.

Public engagement

- Staff actively encouraged the involvement of patients and their carers in things that affected the children's wards. They made use of iPad surveys for example to review the menu, patient experience and provision of play equipment.
- The children's unit encouraged volunteers (who were checked to ensure they were safe to work with children) to come onto the unit to read/play with children.
- There were many fundraising initiatives encouraged by the trust e.g. 24 hour gaming marathon raising funds for the neonatal unit.
- The neonatal unit had a range of information leaflets provided by BLISS (a charity that exists to ensure that all babies born too soon, too small or too sick in the UK have the best possible chance of survival and of reaching their full potential). These leaflets provide information and guidance for parents and carers to help support them in understanding and caring for their babies.
- Children's outpatients had consulted with teenagers using their services to gain their views about how best to design the waiting areas in this department.

Staff engagement

- From time to time on the Tree house unit, a newsletter called Tree house news was publicised. This kept people up to date with staff members' news and current things that were happening.
- Staff were encouraged to suggest training that they felt the whole team would benefit from.

Innovation, improvement and sustainability

- The trust had consultants within the team that were APLS trainers.
- A multi-agency CAMHS project had commenced to improve patient care for CAMHS patients aged over 16 within the hospital and local area.
- The trust had a password-protected system where all consultant's and nursing staff could leave feedback for trainees during their training so a comprehensive record was created for them. This system had received positive feedback from trainees and the Deanery.
- The team took part in the Greater Manchester Strategy in order to make the service stronger and more robust.

End of life care

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

Information about the service

Patients with end of life care (EOLC) needs are cared for on the general wards at Stepping Hill Hospital. Palliative care is also provided on Bluebell Ward which is situated near the hospital at The Meadows and provides care and treatment to patients needing NHS continuing healthcare (CHC). If patients require specialist palliative inpatient care then referrals are made to St Ann's Hospice and the specialist palliative care (SPC) multi-disciplinary team help facilitate this process. The SPC team is based at the hospital.

The mortuary operates under licence from the Human Tissue Authority and provides a full post mortem service to the hospital and the coroner. The mortuary provides body storage facilities for the hospital, the police, and the local community. It deals with approximately 2,500 deceased individuals per year and carries out around 800 post mortems.

The SPC team accepts referrals for any patient aged 16 or over with cancer or any other progressive life-threatening illness where there are complex palliative care needs. Referral criteria include advice and planning care for patients regarding management of complex physical symptoms, and for patients and families or carers experiencing emotional or psychological distress where the level of support required is over and above what the primary carer can provide.

On the 20 January we met with the SPC team lead clinician, the deputy director of nursing, the lead palliative care nurse specialist and the EOLC project facilitator to gain an overview of the palliative and EOL service. In addition to the SPC team, generalist EOLC within Stepping Hill Hospital (SHH) is provided by ward teams and departments, and cancer and non-cancer nurse specialists. The hospital also has close links with St Ann's hospice, an independent adult facility in nearby Heald Green.

Some individual wards have EOLC champions who have chosen to take on additional training for this role to provide support and guidance to other members of the ward team. There is a bereavement lead cancer nurse specialist who provides support for families following the death of a relative.

There were 1521 deaths (including three children) at the hospital between March 2014 and April 2015. During this time there were 581 referrals to the SPC team at the hospital. At a local level, there is recognition that there is a lack of community hospice facilities. Up to 75% of deaths in the Stockport borough occur on the SHH site.

During this inspection we visited seven inpatient wards at SHH: A12 (gastroenterology), A15 (respiratory), E1 Bruntwood (integrated stroke unit), E3 (older people medicine), B4 and C4 (cardiology) and the Intensive Therapy Unit (ITU). We visited Bluebell Ward at The Meadows. We also visited the mortuary, the spiritual centre and the bereavement office.

We observed care, looked at records for 18 people, nine prescription charts and spoke with four relatives, six patients and 26 staff across all disciplines, including doctors, nurses, health care professionals and two volunteers. We spoke with members of the management team, the non-executive lead for EOLC, a porter, chaplains, bereavement officers, and mortuary staff.

End of life care

We observed the SPC team MDT, one ward MDT and part of an EOLC training session.

We visited Stepping Hill Hospital as part of our announced inspection on 19, 20, 21 and 22 January 2016 where

Summary of findings

We found that Stepping Hill Hospital was providing a good EOL service across all five domains of Safe, Effective, Caring, Responsive and Well Led.

Incident reporting systems were in place and actions were followed up at ward level via handover and within the divisions at business group meetings. There was good knowledge of anticipatory EOL care medication within the SPC team which was clinically led by a consultant in palliative medicine. Mandatory training for EOL was excellent and staff knew how to access the SPC team and the safeguarding team when needed.

There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) document which facilitated support for the dying person in the last days and hours of life. There was an audit programme in place for EOLC and the service had taken action to address targets not met in the 2014 National care of the dying audit for hospitals audit.

There was a microsite on the trust intranet where information about palliative and EOLC could be accessed. This included links to the hospice, leaflets, care plans, standard operating procedures and policies and staff said they used it regularly. We saw good evidence of multi-disciplinary and team working, including in the mortuary where staff were working well together in the absence of a manager. There was one nurse from the SPC team on call at weekends but no EOLC medical cover. Access to information was good with a new system (EPAC) in place which allowed different EOLC care providers access to up to date information about their patients.

The completion of DNACPR documentation was inconsistent. Audits had been completed and shortcomings identified but there was still room for improvement and mental capacity assessments were not always completed when required.

EOL care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. The SPC team saw most patients within 24 hours of referral. Patients at the end of life were allocated a side room where possible but unfortunately

End of life care

priority had to be given to patients with infection control protocols in place and patients where there was no same sex bed available on the ward. There was a rapid discharge process in place and this was being audited with actions identified and monitored to address areas where improvement was required. There was evidence that concerns and complaints were addressed at all levels, and that learning from surveys, audits, complaints and incidents was disseminated to staff.

Several of the systems and processes in place around EOL care were very new at the time of our inspection. The individual plan of care (IPOC) which had replaced the Liverpool Care Pathway (LCP) was new and had not yet been rolled out to all staff. Staff said that the safeguarding paperwork was new and they were still getting used to it. The EOL mandatory training was new and had not yet been delivered to all staff. The electronic care portal for anticipatory care (EPAC) was in its infancy. While all of these improvements to EOLC were positive and appropriate, they were not yet fully established which meant it was not possible to fully assess their impact on the patients and the service.

Similarly there were several further developments in the pipeline, including a new forum which would include discussion around EOLC governance including the use of a uDNACPR across all EOL services which was another new development being planned. A performance dashboard to provide an overview of how EOL services were performing against their agreed targets was in draft format. The SPC team was due to be fully integrated between the hospital and the community in March 2016 which will involve further changes. However, the EOLC leads we spoke with had a clear vision of the direction the service was moving in and were working towards it. They were conversant with the latest guidance and had registered for the Transform programme which was developed to provide hospitals with a comprehensive service improvement framework for EOLC.

Are end of life care services safe?

Good

There were good systems in place across the service for reporting incidents and staff knew how to access these. Learning from incidents was discussed at governance and business group meetings, and disseminated at a local level, for example in ward handover.

Management of EOL medicines was good and the SPC team were knowledgeable about what was appropriate for individual patients including consideration of contra-indications and side effects. Record keeping was good although there were some discrepancies with the quality of DNACPR documentation. Staff were aware of safeguarding criteria and would request support from the safeguarding team in the event of a safeguarding concern.

Mandatory training for EOL was excellent, with a new course to be completed every three years by clinical staff regularly involved in the care of a dying person and those closest to them. We observed some of this course being delivered and it was up to date, informative and relevant. The SPC team were up to date with their mandatory training which included syringe driver training. Syringe driver training across the wider services was not up to date. This had been identified as a risk and actions were in place to address it.

Staffing for EOL care was the responsibility of all the staff and not restricted to the SPC team. The SPC team had a whole time equivalent (WTE) of 4.4 nurses in the hospital and they visited the wards to offer support and guidance when requested. The palliative care consultant had six hours clinical time and two hours for the team meeting per week. There was an associate specialist from the hospice who was able to provide some cover when the consultant was on leave but there was no out of hours cover and no specialist palliative medical care provided on Bluebell Ward.

The EOL leads did not have oversight of all incidents at the time of our inspection, due to the business group reporting structure. However, this was being addressed and a new forum was meeting from February 2016 where all incidents related to EOL and palliative care would be reviewed and monitored.

End of life care

Incidents

- There were systems and processes in place to report incidents via an electronic datix system and staff told us they were encouraged to do so. Staff at different levels on the wards and in the mortuary were familiar with the incident reporting system and were able to provide examples of recent incidents.
- Staff on Bluebell Ward gave an example of a recent incident that had occurred on the unit. Following the incident senior staff had been in contact with the family to discuss what had happened and apologise. Lessons were learned around the importance of documenting observations and changes had been made to the positioning of staff at night. The staff involved had completed a reflective piece of work. The outcomes of this incident were discussed in the daily 'huddle' which formed part of handover, and with the individual night staff concerned.
- New EOL incidents were discussed at the bi-monthly SPC governance meeting and the current status in terms of any ongoing investigation was documented. Incidents related to bereavement services were reviewed at the monthly bereavement team meetings and quarterly bereavement working party group. The lead cancer nurse led on bereavement related incidents. We saw evidence that required actions from incidents were discussed and minuted, with target dates and action owners.
- There was awareness by senior staff that there was no robust oversight of all EOL incidents. This was partly due to the way incidents were reported and the governance structure which meant that as part of the community healthcare business group the SPC team only saw incidents they had submitted and not EOL incidents from other areas. Steps were in place to address this, and a new EOLC group was being introduced to replace the former resus group.
- The setup of a new forum had been agreed, which was to include EOL discussions and service development including DNACPR and advance care planning. The first meeting was scheduled for February 2016 and was to be chaired by the palliative care consultant. Future meetings were to be chaired by the medical director.
- All EOL incidents will be reported into these meetings, and any identified recurring themes will be taken to the relevant business group monthly quality board. There was also a quality assurance committee where incidents could be discussed, although there was acknowledgment from senior managers that this needed more input from EOL services.

Medicines

- The trust achieved its National Care of the Dying Audit of Hospitals (NCDAH) organisational key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at EOL.
- We looked at nine prescription cards (including two paper records on Bluebell) which were clear and concise with non-essential medicines discontinued where appropriate in EOLC.
- Recommendations (NICE guidelines CG140, QS13 and Gold Standard Framework 'Just in Case' good practice) for the prescription of anticipatory medicines suggest that patients often experience new or worsening symptoms outside doctors' normal working hours so medicines should be prescribed for the alleviation of pain and shortness of breath, nausea and vomiting, agitation and respiratory secretions.
- Anticipatory medicines prescribed included analgesia for pain and sedation for agitation but on two cards on Bluebell Ward there was nothing prescribed for nausea, secretions or shortness of breath as recommended. Reasons for this were not documented.
- We observed good discussion around different EOLC medications at the SPC MDT. The team were knowledgeable about the side effects and contra-indications of particular medicines.
- Storage of medicines on Bluebell Ward was appropriate, with controlled drugs kept securely in a locked cupboard, within a locked room. All nurses knew the code to the locked room, but the keys for the controlled drugs cupboard were held by the nurse in charge.
- Two nurses checked the stock of controlled drugs twice daily. We examined the controlled drugs register which was correct and up to date.

Records

- Most of the patient records were in paper format although observations, early warning scores (EWS) and prescription cards were recorded electronically at SHH. On Bluebell Ward all of the records were in paper format including a drug kardex system.

End of life care

- We reviewed 18 sets of case notes. Three had individual plans of care (IPOC) in place and all had clear and full assessments of the patient's needs, including Malnutrition Universal Screening Tool (MUST) assessments for establishing nutritional risk, hydration status, fluid balance charts, falls risk and pressure sore assessments.
- Records for deceased patients were labelled with stickers, and left the ward with the patient. When a patient died on Bluebell Ward the care records were sent over to SHH in a taxi.
- We looked at 18 trust DNACPR forms with mixed results. All were legible, signed by appropriate clinicians, had a summary of why CPR was not in the patient's best interest and were recorded in the medical notes on the same day. All were indefinite and all but one were discussed with the families but only one included a summary of communication with the patient. One DNACPR was tatty, damaged and loose in the notes and one due for review on 7th December 2015 had not been reviewed until 28th December 2015.
- There were no formal ceiling of care documents but three records documented 'for ward based care only' to indicate the patient was not for escalation to a higher level of care, and provided other details about what level of care was appropriate in terms of antibiotics and non-invasive ventilation.
- The trust had a plan to move to all electronic patient records by 2018 but there were a number of electronic recording systems already in place as well as the EWS and prescription cards. One system (InteRCom) was a data reporting system that included information as to whether or not the patient had cancer and this data was used to audit the SPC team's non-malignant caseload.
- Everyone registered with a Stockport GP had a Stockport health and care record which contained a new EOL electronic care portal for anticipatory care (EPAC) record if one was in place. At the time of our inspection 13 hospital patients had an EPAC record, and 60-70 had been created across the region. There needed to be between 400-500 EPAC records in place for it to be fully operational.

Safeguarding

- Staff were aware of safeguarding criteria and would request support from the safeguarding team in the event of a safeguarding concern.
- Staff said the safeguarding paperwork was quite new to them, so senior staff provided support to those who were less confident with the processes.

Mandatory training

- Mandatory training included the provision of EOLC and the individual responsibilities of staff. There was a three hour training session for all clinical staff regularly involved in the care of a dying person and those closest to them and a one hour training session focusing on compassion and communication for those who may come into contact with a dying person or those closest to them. There were also EOLC training sessions scheduled specifically for medical staff. The palliative care consultant was one of the clinical staff who delivered this within the specialist registrar training which is within foundation year and medical training.
- The course objectives were set out to align with recommendations made by the regional strategic clinical network's document, Principles of Care and Support for the Dying Patient (2013) around the expected practice of competent professionals.
- The course was completed three yearly. At the time of our inspection 284 staff had completed the EOL training. The trust were not able to provide information on how many staff were still due to complete the training due to ongoing staff changes and the nature of the doctors' rotations but it was being monitored as part of the mandatory training programme to ensure all staff completed the course.
- We attended part of the EOLC training which was taking place during our inspection and saw good attendance from a cross section of staff including nurses at different grades from the community and the hospital. The training was relevant with reference to current legislation and EOLC guidelines. It was effectively delivered with consideration to different learning styles, for example didactic teaching, group work, video and discussions. The facilitators were sensitive to the needs of the staff, and gave attendees the chance to leave, for example if they were recently bereaved.
- Enhanced communication training was mandatory for qualified nursing staff working at band 6 and above level. This had only recently been introduced and staff were scheduled to attend over the coming year. Sessions were also available to other staff and the qualified APTs in the mortuary had completed the training.

- Training for the new IPOC document was ongoing. At the time of our inspection 18 wards had completed the training, five wards were partially trained and five were yet to start the training. The aim was to have all wards trained by April 2016.
- A full time recurrent post was in place for a band 6 implementation coordinator who was going to deliver EPAC and advance care plan training and develop an e-learning package over the next 12 months.
- The SPC team, including the consultant, had annual syringe driver training. Ward staff told us that most syringe driver training was delivered by their peers.
- A risk assessment provided by the trust from October 2015 indicated a recent audit had shown only 25% of relevant staff were up to date with syringe driver training and a large number of staff were not updating their competency on a yearly basis as per the trust standard operating procedure (SOP). The training was not being recorded on the medical devices data base.
- The trust SOP required each ward to have a clinical practice facilitator (CPF) to undertake a train the trainer programme then train users within the ward or department. A reminder had been sent to all business groups of wards that were non-compliant with training to allow time for staff to be updated.

Assessing and responding to patient risk

- Staff used an early warning scores system to alert nursing and medical staff that the patient's condition had deteriorated. Documentation was transferred to an individual plan of care (IPOC) when it was recognised the patient was expected to die within hours or a few days. We saw evidence of this process for one patient during our inspection and reviewed the IPOC which was completed appropriately.
- Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.
- Nursing staff were aware of patients' increased needs such as mouth care. They gave examples of interventions used, for example sponges to moisten lips, artificial saliva spray to prevent dry mouths and soft paraffin for dry lips. There were care plans in place for mouth care and on Bruntwood Ward (E1) a staff nurse with a special interest in mouth care was developing an oral hygiene mouth care plan for the stroke unit.
- The service used McKinley syringe pumps which were portable, battery operated devices for delivering medications by continuous subcutaneous infusion. These could be ordered from medical electronics via a helpdesk on the trust microsite or accessed direct via the porters out of hours. They could also be ordered via the 'ibleep' co-ordinator.
- EOL patients were known to the team from discussion at handover. There were no icons in place to identify EOL patients on the whiteboard or on the front of their notes.

Nursing staffing

- Staffing for EOL care was the responsibility of all the staff and not restricted to the SPC team.
- The SPC team had a whole time equivalent (WTE) of 4.4 nurses in the hospital, plus an EOLC project facilitator, and 4.8 in the community. There was some overlap with hospital staff visiting community patients and vice versa, to ensure continuity of care.
- The hospital SPC nursing staff included a lead nurse, three clinical nurse specialists (band 7), two associate clinical nurse specialists (band 6) and an EOLC facilitator (band 7). There was also an advance care plan and EPAC facilitator (band 6).
- Bluebell Ward had establishment figures of eight staff (three qualified and five health care assistants) in the morning and seven staff (three trained and four untrained) on the late shift. On nights there were four staff (two qualified and two healthcare assistants). There was an extra healthcare assistant on a twilight shift between 4pm and 11.30pm to help with fluids for patients. This met with guidance from the National Institute for Health and Care Excellence (NICE) safe staffing for nursing in adult inpatient wards in acute hospitals.
- Some, but not all of the wards had link nurses for EOLC. The EOLC link nurses supported other staff with care, for example completion of EOL paperwork and how to talk with family members of EOL patients.
- The SPC nurses would visit Bluebell Ward at the Meadows when requested. This was usually to support relatives or advise when particular medications were not working as expected.

Medical staffing

- The palliative care consultant had 1.5 programmed activities (PAs) per week, each having a timetabled value of four hours. This totalled six hours for EOLC at the hospital during normal working hours, plus another two

hours for the weekly multi-disciplinary team (MDT) meeting. Since recently relocating to be based on the hospital site the consultant was available outside of these hours and did give extra time when needed where possible.

- The palliative care consultant held once weekly 45 minute board rounds where the status of EOL patients was reviewed. These were attended by the specialist palliative care team only which includes the EOLC Facilitator and Palliative care pharmacist.
- The palliative care consultant provided a link between the trust and St Ann's hospice. He was part of their on call rota and attended relevant meetings within the hospice including hospice referrals meetings twice a week.
- There was no medical cover out of hours for EOLC. The associate specialist at the hospice attended the weekly SPC MDT and provided cover "where possible" but it was acknowledged by their service there were gaps in specialist medical provision.
- Two consultants in elderly care from Stepping Hill hospital visited Bluebell Ward to conduct ward rounds twice weekly. Half of the patients were seen on a Tuesday morning ward round, and the other half were seen on a Thursday morning ward round. The two consultants provided cover for each other.
- GP cover was provided between 7am and 7pm on Bluebell Ward and a GP attended daily for about an hour at lunchtime, Monday to Friday. Between 7pm and 7am and at weekends medical cover was provided by an out of hours GP service.
- There was no specialist medical palliative care cover for Bluebell Ward.

Major incident awareness and training

- Mortuary staff were fully conversant with their business continuity plans. They had capacity for 104 bodies which had previously been reached and managed effectively. They were able to describe the contingency plans which would be put in place in the event of reaching capacity or a major incident. These included using capacity on other sites, temporary facilities in the car park and regional agreements including the use of mothballed mortuaries.
- Some ward staff we spoke with were unaware of any business continuity or major incident plans. They said in the event of a major incident they would bleep the relevant matron. Others knew where to find information from the trust microsite and gave examples of actions they would take, for example calling staff in from leave and allocating areas for new patients.

Are end of life care services effective?

Good

The service had introduced an individual plan of care and support for the dying person in the last days and hours of life (IPOC) document to replace the Liverpool Care Pathway. Staff using the document were positive about it. There was an audit programme in place for EOLC which included an audit on the recognition and communication of Gold Standard Framework (GSF) Prognostic Indicators for which an action plan had been developed. Other audits showed an improvement in meeting EOLC standards.

There was a palliative and EOLC microsite where information about palliative and EOLC could be accessed. This included links to the hospice, leaflets, care plans, standard operating procedures and policies and staff said they used it regularly.

We saw evidence that pain relief was being managed effectively and that nutrition and hydration needs were being appropriately assessed and monitored. The service had taken action to address targets not met in the 2014 National care of the dying audit for hospitals audit. We saw a draft dashboard in the developmental stages which when completed would provide the service with a comprehensive overview of how they were performing against their agreed targets.

Staff felt supported in the professional development and members of the SPC team all had post registration qualifications in areas relevant to EOLC. We saw good evidence of multi-disciplinary and team working, including in the mortuary where staff were working well together in the absence of a manager.

There was one nurse from the SPC team on call at weekends but no EOLC medical cover. The bereavement office and the mortuary had arrangements in place for out of hours cover. Access to information was good with a new system (EPAC) in place which allowed different EOLC care providers access to up to date information about their patients.

End of life care

The completion of DNACPR documentation was inconsistent. Audits had been completed and shortcomings identified but there was still room for improvement and mental capacity assessments were not always completed when required.

Evidence-based care and treatment

- The service had introduced an individual plan of care and support for the dying person in the last days and hours of life (IPOC) document which was being rolled out across the trust in a programme due to be completed in March 2016. A decision was made to deliver the IPOC training in small groups, to try to ensure that staff understood it fully prior to implementation, rather than setting an earlier completion date for rollout which may have resulted in staff starting to use the document without the appropriate knowledge and skills.
- Some of the ward staff we spoke with had begun to use IPOC. On Bruntwood Ward (E1) they had been using it for about six months and said it was a positive change that worked well and was tailored to the individual patient and their families. Some ward staff were concerned about the time the IPOC was going to take but staff already using it said although the document was lengthy it was often the case that the patient was already known to them, and therefore much of the information that went on the form had already been discussed.
- The Gold Standards Framework (GSF) is a programme that enables staff to provide a gold standard of care for people nearing EOL by planning care in line with their needs and preferences. There was an audit programme in place for EOLC which included an audit on the recognition and communication of GSF Prognostic Indicators for which an action plan had been developed.
- The service provided to us the results of a documentation review process designed to provide an insight into care delivered to dying patients and their families and establish whether national EOLC guidance, One Chance to Get it Right (Leadership Alliance for the Care of Dying People) was followed. Between April and September 2015 93 sets of case notes were reviewed. There were some positive findings, including that all notes showed discussions had been held with patients or those closest to them around EOLC (with the exception of 3 where the family were unable to be contacted). 92% of notes where dying was recognised had medical plans in place and increasing numbers of IPOCs were being produced within pilot wards (39% compared to 22% in 77 records audited between October and December 2014). Increasing numbers had all recommended medications pre-emptively prescribed (87% compared to 77% previously).
- Results were taken to the divisional business group and the quality governance committee with some considerations including a request to consider whether the environment for dying patients, those closest to them and the newly bereaved was “fit for purpose”.
- We saw evidence that staff were aware of the Priorities for Care of the Dying Person as set out in One Chance to Get it Right. Posters setting these out were on display and on Bluebell Ward they had created a diagram which explained their role in each priority.

Pain relief

- The most recent (2014) National care of the dying audit for hospitals (NCDAH) showed that clinical protocols for the prescription of medications prescribed for the five key symptoms that may develop at the end of life were achieved at a better rate (69%) than the national average (50%) for England.
- We saw good discussion between the specialist nurses and the consultant at the SPC MDT around a patient with specific health needs. There was understanding of which opioid to use for effective pain control and the options for which mode of administration to use for certain drugs, for example oral, patch or subcutaneous injection.
- We reviewed nine prescription charts and saw evidence of pain relief being appropriately prescribed as anticipatory medication.
- The trust had guidance on EOL medication and pain relief which was adapted from St. Ann’s hospice algorithms. This was available on the trust microsite and included advice, key messages and numbers to call for further information and guidance.
- There was a dementia link nurse on Bluebell Ward who used a dementia pain assessment chart when appropriate.

Nutrition and hydration

End of life care

- We reviewed 18 care records and saw good evidence that assessments were being undertaken for hydration and nutritional status and that fluid balance charts were being completed.
- The IPOC included a comprehensive nutrition and hydration care plan which included advice and guidance for staff. We saw these in use.
- On Bluebell Ward there was a patient list detailing any special dietary requirements in the servery.

Patient outcomes

- In the most recent (2014) NCDAH the trust achieved only two of the organisational key performance indicators (KPIs) and these were in relation to trust board representation and planning for care of the dying and clinical protocols for the prescription of medications for the five key symptoms at the end of life.
- The five organisational KPIs not met included access to information relating to death and dying, access to specialist support for care in the last hours or days of life, continuing education, training and audit, formal feedback processes regarding bereaved relatives/friends views of care delivery and the clinical provision/ protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient.
- Action had been taken to address these shortcomings and at the time of our inspection there was information available for relatives and an education programme in place for EOLC. Bereavement surveys were being undertaken and the IPOC was being rolled out.
- For the NCDAH clinical KPIs the trust percentage of cases which met the requirements were all higher (better) than the national average.
- The Transform programme was developed to provide hospitals with a comprehensive service improvement framework for EOLC and focused on five key enablers: advance care planning, electronic palliative care co-ordination systems, the Amber care bundle, rapid discharge and the IPOC. The service had registered to sign up to Transform and were working on these enablers with the exception of the Amber care bundle.
- The service was not using the Amber care bundle which is a tool designed to help patients and their carers to be fully involved in making decisions about their care in the last one to two months of life. The team felt it was difficult to make judgements around when this was appropriate to introduce the tool.
- Work was ongoing to develop a palliative and EOLC performance dashboard. We saw the draft dashboard which had been designed to show how the service was performing against the North West EOLC model. This was a model of delivery advocated by the North West palliative and EOLC operational group and moved from recognition of need for EOLC, to care after death.
- The dashboard included topic areas and was divided into the five sections which represented the palliative and EOLC model. These were advancing disease (the last 12 months of life), increasing decline (the last six months of life), the last days and hours of life and the first days of death and bereavement. There was also a section on EOLC development and training.
- The new EPAC records would provide data for how many EOLC patients were given the opportunity to die in their preferred place of care.
- The dashboard was in the developmental stages but when completed would provide the service with a comprehensive overview of how they were performing against their agreed targets. This would enable best practice to be shared around areas of strength, and actions to be taken to improve areas where weaknesses were identified.

Competent staff

- The members of the hospital SPC team had completed a range of courses between them, with all of the nursing staff having gained post registration palliative care qualifications. They had also all completed training in advanced communication skills and advanced pain and symptoms. They had a range of training the trainer and teaching qualifications between them, which enabled them to deliver training to other staff.
- Training on advance care planning was available on a rolling programme and between January and December 2015 this had been completed by 280 staff including nurses, allied health professionals, support workers and students.
- The SPC team provided training to staff around symptom management and mouth care. Training records were reported to the divisional business group.

- A piece of work to develop EOLC competencies was underway and the first draft had been completed. The lead SPC team nurse was due to liaise with the organisational training and development lead to develop the supporting documentation and appraisal process.
- Staff at different levels said they felt supported with their professional development and were encouraged to attend courses. A member of staff in the bereavement office had completed a counselling course three years ago to equip her better to support families. This was completed in her own time but she felt supported by the trust which paid for the course.
- The chaplaincy held a 'good grief' training day twice a year where religious practices of different faiths were shared, for example handling the body and legal considerations. The coroner attended twice a year. It was advertised on the chaplaincy microsite and was well attended.

Multidisciplinary working

- There was a weekly MDT team meeting attended by the palliative care consultant and representation from the SPC team, the hospice, Beechwood, chaplaincy, the respite service, social work and mental health. We observed an SPC MDT attended by the above, plus a dementia nurse, pharmacist and dietician. We saw good discussion of patients including those who had recently died. There was evidence of holistic care including consideration of the patients' physical, psychological and social needs with good MDT working.
- The SPC team had a hospital team and a community team. Both teams worked together to integrate their services across four community locations and the hospital. Ward staff told us there was good support from the SPC nurses who would come to see patients when requested.
- We observed one ward MDT attended by medical staff, nursing staff and allied health professionals. We saw appropriate and informative discussion about one EOLC patient whose documentation was complete including the DNACPR, ceiling of care details, anticipatory medication and a recently commenced IPOC.
- There was good communication between staff on the wards with systems in place to update each other, for example an update file with information that staff needed to read, with a signature sheet to be signed and dated. One ward manager attached notes to payslips with updates, tasks and 'thank yous' as and when required.
- The new EPAC system was designed to coordinate care across different areas. Providers of care could input and view information about a palliative patient once they had given their consent. Services had different access levels so some could input and view information, whereas others could only view but not add to or edit a patient record. The 111 service and the ambulance service were unable to use it at the time of our inspection but the system was in its infancy and discussions were underway as to how it could be developed.
- The routine day to day mortuary activities were carried out by two anatomical pathway technicians (APTs) and one trainee APT. There was an administrative co-ordinator based in pathology. The manager and another member of staff had recently left their posts but despite the resultant staff shortages the team were working well together. There was a huddle every day at 4pm where the pathologist discussed post mortems scheduled for the following day.

Seven-day services

- There was no formal medical provision for EOLC out of hours or at weekends. Ward staff said they could ask the doctors if they needed advice regarding EOL medication, or access a helpline at St Ann's hospice if a patient's symptoms were proving difficult to manage.
- There was one nurse from the SPC team on call at weekends.
- Bluebell Ward used an out of hours GP service between 7pm and 7am and at weekends however there was a cost implication to this with a set fee in place for every telephone call made and every visit undertaken. Staff told us this did not prevent them from using the service when necessary.
- The APTs in the mortuary were on call Monday to Thursday and attended if called out to receive deceased patients from the police or for the coroner. The APTs alternated between each other to cover on-call at week-ends.
- Viewings in the mortuary were accommodated out of hours before 8pm for coroner's and hospital deaths, and at week-ends the on-call staff came in for half hour viewing appointments when required.

End of life care

- In the bereavement office there was a '24 hour box' containing all the necessary documentation to enable a doctor to issue medical certificates of cause of death (MCCD) out of hours. This could be accessed via the site manager. This was particularly important where bereaved families were of a faith requiring immediate access to death certificates in order for arrangements for their loved ones to proceed.

Access to information

- There was a microsite on the trust intranet with information about palliative and EOLC including pathway documents, links to the hospice, leaflets, care plans, standard operating procedures and policies and other EOL tools. All the nursing staff we spoke with said they used the microsite which we saw, with the links to all the information as described.
- Staff were aware of and had access to the GSF prognostic indicator guidance (PIG), the national GSF centre's guidance for clinicians to support earlier recognition of patients nearing the end of life
- Some of the wards had developed EOL packs, containing paper copies of the IPOC, a visitors car parking permit application form for relatives and an algorithm providing guidance on symptom control.
- If the patient consented the SPC team created or updated a Stockport EPAC record when they received a referral for an EOL patient. This could be accessed by other services for up to date information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- Of 18 DNCACPR forms we reviewed, six were not discussed with the patients due to no capacity, long term dementia and/ or poor communication. We saw only two completed mental capacity assessments. One patient had a DoLs that had expired.
- DNACPRs did not travel with the patients and the SPC team leads were aware that this needed reviewing. Good practice specifies the DNACPR should be the property of the patient and the service were working towards implementation of the North West uDNACPR policy which states the lilac copy of the form must stay with the person at all times. The aim was for all the linked services including the hospital, community, the hospice and NWAS to be using one unified DNACPR. This was to be addressed at the new forum starting in February 2016 but as yet there was no clear rollout plan with actions and target dates for the uDNACPR.
- A DNACPR audit was completed in April 2015. The audit looked at records of 39 medical patients and 8 trauma and orthopaedic patients known to have had a DNACPR decision made. Audit results showed some improvements when compared with previous audits; however the field for a patient's resuscitation status was completed in only 83% (39) of cases. In 17% (8) of cases it was left blank. Only 2% of forms had a review date set and for the 98% where no review date was set an explanation was given in only 44% of the cases. Audit results were sent to the divisional business groups for actions.
- We observed MCA issues being discussed appropriately at the SPC MDT meeting.
- Ward staff were aware of DoLS procedures and there were DoLS patients on the wards at the time of our inspection. Documentation was completed on the ward, with support from the safeguarding team. Staff said the DoLS paperwork was quite new to them, so senior staff provided support to those who were less confident with the processes.
- Staff on one of the elderly wards said 80% of their patients suffered from dementia and all staff were able to complete a simple capacity assessment form available on the microsite. More in-depth or formal assessments were carried out when needed by a consultant or a social worker, for example for CHC funding. If staff needed advice or support, they had access to a mental health liaison nurse, and the rapid assessment, interface and discharge (RAID) team who provided psychiatric liaison and assessments across the hospital site.

Are end of life care services caring?

Good

End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. Family members we spoke with were positive

about the way they and their relatives were treated. Ward, mortuary and portering staff were respectful and caring when they spoke about their patients who were at the end of life.

Staff were mindful of considering the preferred place of care for patients and their families. The ITU had developed and implemented a multi-faith bereavement service that was held in high regard by both families and staff. It was run by a team of like-minded critical care nurses, often in their own time, providing a source of sensitive support for families as they came to terms with their grief.

There was a proactive chaplaincy team who offered support to all patients and their families regardless of faith. Bereavement services were in place and offered to all families

Flexible visiting was offered where possible but facilities for families to stay with their relatives were limited.

Compassionate care

- The patients we spoke with described the staff as very caring. One family we spoke with were being well looked after, had had drinks brought to them, been offered open visiting and a parking permit and said "they are outstanding" when asked about the staff.
- Families felt listened to in relation to their preferred place of care and did not feel pressured to move their relatives if they were comfortable where they were.
- Staff were communicating appropriately and regularly with patients and relatives. One family said they had not needed to use the call bell as there was usually a nurse stationed nearby.
- Surveys were carried out by the bereavement service at Beechwood cancer care centre. Survey results were evaluated by the EOLC facilitator and fed back to the relevant wards and departments. We saw evidence of this feedback during our inspection. Where necessary, wards would develop actions plans to address concerns raised; however all the feedback we saw was positive.
- Ward staff said they offered flexible visiting for patients at the end of life but unfortunately there were no facilities for relatives to stay overnight. One ward had borrowed a folding bed from the children's ward on one occasion, but generally families made do with chairs at the side of the bed or in a day room area. Tea and biscuits could be provided on the ward but otherwise families were directed to the on-site restaurants.
- Porters transferred deceased patients to the mortuary, referred to by some staff as 'Rose Cottage', and a senior porter (charge hand) had to be present. Only charge hands had access to the refrigeration room. We spoke with one of the porters who said the trolleys have sides and are covered with a blue canvas to maintain privacy and dignity for the patients. They try to transfer bodies as soon as possible after they are called, but try to avoid visiting hours.
- Appointments to view a patient who had died in hospital were made through the bereavement office.
- There was a viewing room in an office area of the mortuary where relatives could look through the window before deciding whether or not to enter the viewing area.

Understanding and involvement of patients and those close to them

- When a patient died at SHH nursing staff would telephone to inform the family if they were not already there. The doctor would be asked to certify the death and the family were given "plenty of time" with their relative. They would be given information by the ward staff about registering the death, and who they needed to contact.
- Information was also provided to the families by the bereavement office. This included practical information and advice about what to do after a death and information about local bereavement and counselling services.
- On Bluebell Ward visiting times were 2-4pm and 7-8pm. These times were displayed in patients' rooms and on the ward. Staff told us that these could be flexible however changes to these times would need to be discussed with the nurse in charge.
- Patients' rooms on Bluebell Ward had personalised wooden name plaques on the doors and bright, individual quilt covers on the beds. Some were patients' own, and others had been donated.

Emotional support

- Bereavement services were available to all bereaved carers and family members of patients who died at SHH. The services were provided by Beechwood cancer care centre which worked in partnership with the trust. Relatives and carers were given an information leaflet detailing the support offered, when they attended the bereavement office to collect the medical certificate.

End of life care

- There was a chaplaincy service which included approximately 20 volunteers who had completed a six week training course as part of their induction. The chaplains and the volunteers had their own allocated areas of the hospital which they visited regularly and the volunteers would refer patients to the chaplains when requested, for example to take communion. The chaplaincy service talked to all patients, regardless of faith, and described themselves as providing "a listening ear".
- Porters or healthcare assistants took patients to the chapel on a Sunday if requested.
- The chaplaincy also attended Bluebell Ward two or three times per week, and conducted memorial services and carol services at appropriate times. Usually there was a memorial service every two months dependant on the number of deaths. Families whose relatives had died in the weeks before the service were invited to attend. We saw evidence of written feedback from families detailing how helpful and supportive they had found the services.
- Some staff on the intensive therapy unit (ITU) had developed a bereavement team and over time had introduced the use of a bereavement box on the unit. This brought together in one place, information and materials that enabled the staff to better manage the EOLC for their multi-faith patients. For example the box contained the equipment needed to take hand prints and locks of hair as keepsakes. There were also copies of the Bible, the Koran and The Torah.
- The bereavement team on ITU met formally twice a year to share experiences and reflect on the service provided. The staff involved were from nursing, medicine and chaplaincy backgrounds and were passionate about providing excellent EOLC. Much of the bereavement team's work was undertaken in their own time.

Are end of life care services responsive?

Good

The SPC team saw most patients within 24 hours of referral. Patients at end of life were not pressured to transfer if they did not wish to be moved. When a patient died, relatives were given the time they needed before transfer arrangements were implemented. There was good awareness of processes for deaths of people from different faiths and the new IPOC had a section for identifying specific faith needs.

Bluebell Ward had several facilities in place for dementia patients including a reminiscence area and a large display showing the time and date.

There was a rapid discharge process in place and this was being audited with actions identified and monitored to address areas where improvement was required. There was evidence that concerns and complaints were addressed at all levels, and that learning from surveys, audits, complaints and incidents was disseminated to staff.

EOL patients were allocated a side room where possible but unfortunately priority had to be given to patients with infection control protocols in place and patients where there was no same sex bed available on the ward.

Service planning and delivery to meet the needs of local people

- Figures provided by the trust showed that between April 2014 and March 2015 90% of referrals to the SPC team were seen within 24 hours. The latest figures provided for referrals between July and September 2015 showed 89% were seen within 24 hours. Figures for March 2014 to April 2015 showed the team was compliant with their KPI 1 that 95% should be seen within 5 days and KPI 2 that 95% of urgent referral patients were seen within 24 hours.
- Staff from different wards spoke to us about considering the wishes of EOL patients and their families when planning care, including consideration of the preferred location. There was a patient from out of area on one of the wards who was not eligible for Bluebell Ward as he did not have a Stockport GP. He could have been transferred to a service in his own area, but was staying on the ward as this was what he and his family requested.
- Staff said they would generally not want to transfer an EOL patient to Bluebell Ward in their last days and hours if they had been on the ward for some time and had developed a relationship with that person. Usually a transfer would take place if a palliative patient was expected to live for a number of weeks or months. Other

factors also sometimes influenced the decision to transfer a patient, for example a patient with very noisy breathing may be better be better placed on Bluebell in a single room.

- EOL patients were allocated a side room where possible, but priority was given to patients who needed isolating due to infection, and to ensuring that the requirements regarding same-sex accommodation were met. For example, if a male patient required a bed but the only bed available on the main ward was in a female bay, a female EOL patient may need to be moved out of a side room into the available bed, and the male patient would be admitted to the side room.
- Several staff members from different areas felt that the limitations around prioritising side rooms for patients was the biggest weakness in EOL care at SHH however they tried to use the quieter bays and were mindful of pulling curtains to try and ensure privacy and dignity.
- When a patient died, nursing staff would deal with any cannulas and catheters to prevent them from leaking. Patients were wrapped in new disposable white sheets and disposable blue sheets were placed under the patient to allow them to slide from the bed without disturbing the sheeting. There was an EOL last offices checklist for staff to work through. This included prompts to wear protective equipment where there were infection control considerations.
- Nursing staff would telephone the porters to come and transfer the patient to the mortuary. Nursing and portering staff said there were no problems with delays. Families did not go with their relatives to the mortuary.
- All 25 rooms on Bluebell Ward were single with en-suite facilities.
- When a patient died on Bluebell Ward they were taken by a private undertaker to the mortuary at SHH. Families could not travel with them.
- The mortuary was a public mortuary so received bodies from the police, for example following a road traffic accident, and from other services where a post mortem was required for the coroner.
- The mortuary had times set aside for specific activities, so blocks of time throughout the day were allocated for families of patients who had died at the hospital and for appointments related to coroner's cases, for example formal identifications. Post mortems were usually carried out in the mornings, to allow for cleaning in the afternoons.
- The bereavement office was staffed between 8.30am to 5.00pm Monday to Friday. The registrar attended the hospital between 9.40am and 3.00pm twice weekly which provided eight time slots available for families to register a death without having to visit the town hall.

Meeting people's individual needs

- There was good awareness of processes for deaths of people from different faiths and the new IPOC had a section for identifying specific faith needs.
- Staff gave examples of dealing with particular faith requests when a patient died and were familiar with some of the different practices which they always tried to accommodate, for example some Muslim families preferred to tend to the patient themselves after death.
- The chaplaincy service included representation from different branches of the church. There was a multi faith room available to patients, relatives and staff. In the chapel there were slips of paper for people to write remembrance notes and prayers on. These were in the form of icicles in winter, leaves in autumn and bunting in summer. They were hung on a tree by the chaplains.
- There were four large portable bed chairs on Bluebell Ward. These were used to enable very unwell patients who were otherwise immobile to leave their bedrooms for a change of scene.
- On Bluebell Ward there was a spacious lounge area with a stocked book shelf, various different sources of music (record player with records, cassette player, and radio), a television and some games and puzzles. There was a reminiscence area with a vintage telephone, an old fashioned 'dolly brush', knitting patterns and memory cards. Reminiscence therapy is recommended in guidance from the National Institute for Health and Care Excellence (NICE), Dementia: supporting people with dementia and their carers in health and social care.
- The time and date were prominently on display on Bluebell Ward. The provision of memory aids to orient patients to time and date can help to ease anxiety for dementia sufferers or patients who may be confused and are not in their usual environment.
- There was a world religions poster on display on Bluebell Ward, with a festival calendar.
- There was a relatives room on Bluebell Ward where family members could make refreshments such as tea and toast. There was a microwave and fridge available

for them to bring their own food, or they could order meals from the catering service during the day. Folding beds were available for relatives who wanted to stay on the ward with EOL patients.

Access and flow

- One of Stockport Clinical Commissioning group key performance indicators (KPIs) was that 80% of patients eligible for rapid discharge were discharged within 48hrs. The trust's rapid discharge process supported patients with an expected prognosis of less than two weeks, to be discharged from hospital to their preferred place of care within 24 hours where possible.
- The service had an agreement with the North West Ambulance Service (NWAS) to facilitate a level of transport that was clinically appropriate, and allowed for carers or relatives to travel if required, within two hours of the booking request being made (with provision for other circumstances set out).
- Between October and December 2015 five (55%) rapid discharge patients had been discharged within 48 hours with four (45%) taking longer. One delay was due to a doctor requesting a blood transfusion prior to discharge and two were due to availability of carers at a weekend. The other had no reason specified.
- In 2015 27 patients were discharged within 48hrs and of these nine went home within 12 hours, eight within 24hrs and ten within 36hrs. Data from January to October 2015 had been reviewed, with meetings held and action plans in place to address reasons for delay. These included working with pharmacy to speed up the preparation of prescriptions, and agreeing support from the district nursing teams for ordering equipment.
- There was provision on Bluebell Ward for palliative and EOL patients. 21 of the 25 beds were occupied when we visited, with one patient on EOLC. Two admissions were expected later in the day.
- Patients on Bluebell Ward were those were under the care of a Stockport GP who met the criteria for CHC but had continuing complex healthcare needs that warranted continuing admission to hospital. Staff told us that most patients on Bluebell had a DNACPR in place.
- When a bed became available on Bluebell Ward there was a 24 hour turn around period before the room was available for a new admission, to allow cleaning and preparation for a new patient.
- Patients admitted to Bluebell Ward needed to have their medication prescribed prior to admission and bring it with them.
- The mortuary had capacity for 104 bodies with extra capacity at two other hospital trusts when required. They had a good relationship with local funeral directors with timescales agreed for collection of bodies.

Learning from complaints and concerns

- The deputy director of nursing met monthly with the SPC team lead nurse to review any negative feedback received about EOLC or from bereavement surveys. Ward action plans were reviewed at these meetings and if issues remained they were monitored and a new action plan was requested.
- Path News was published two or three time a year by the department of laboratory medicine (which included mortuary and bereavement services) to provide information from the department including updates from surveys, audits, complaints and incidents.
- The SPC team carried out their own patient survey in April 2015 and achieved a 54% response rate with 29 of 54 surveys returned. This survey was discussed at the SPC team's governance meeting where actions were agreed to address concerns raised, including telephone contact with team members between visits and reviewing arrangements when team members were absent. 76% knew how to make a complaint regarding the service should the need arise.
- Another survey was conducted in August 2015 when a 52% response was achieved with 31 of 60 surveys returned. 71% knew how to make a complaint regarding the service should the need arise. The responses were largely positive so no action plan was required; however the team were pro-active in listening to their patients, and acting to make improvements when concerns were raised.

Are end of life care services well-led?

Good

We rated well-led as good

There was a knowledgable non-executive director who led for EOLC and was passionate about the service and the dedication of the EOL staff. The SPC team described

themselves as being in a period of transition until the end of March 2016 when the hospital and community teams were to become fully integrated; however there was a clear vision for the direction of the service.

There was an open and positive culture in the areas we inspected. Staff were proud to work in the service and overall felt supported by local and trust management. One manager had worked for the service for 16 years and said that recent changes had resulted in increased support which motivated staff.

The governance structure included a protocol for risks identified in the EOL service to be included on the community business group risk register however we reviewed this and it did not include any risks related to EOL services. The one risk that was recorded was entered in a separate register consisting of only this one item. Other acknowledged risks were not included on either register. While senior staff had a good awareness of identified risks, the lack of one comprehensive risk register for EOL services meant that potential risks may not be managed as effectively as they could be.

Vision and strategy for this service

- There was a non-executive director who led for EOLC. She was knowledgeable and enthusiastic about the service and described the EOL staff as "giving their all".
- There was a focus on seamless working between the hospital and the community, with the emphasis being on the individual care plans and meeting the patients' needs, rather than restricting the patients' needs to fit in around services. This was expressed throughout the service, at a very senior level as well as by staff on the ground.
- There were plans in place to re-model the provision of EOLC and the SPC team described themselves as being in a period of transition until the end of March 2016. At the time of our inspection the team had re-located to be hospital based, but despite some overlap was still primarily split into designated areas of either hospital or community. Future plans were to integrate into one team across the hospital and community services, with the named nurse following the patient between home and hospital, rather than handing over to the team.
- The service was part of the palliative and EOL strategic network which set the priorities and areas of work to develop and improve services in Greater Manchester, Lancashire and South Cumbria. The network was led by senior clinicians, supported by the strategic network team, and overseen by the palliative and EOL steering group made up of commissioners, service providers, patients, carers and members of the public.

Governance, risk management and quality measurement

- The KPIs for the EOL service were discussed within the divisional business group and any issues were taken to the quality board meetings.
- There were divisional risk registers maintained by the business groups and reviewed at the quality board meetings. Any risks with a residual risk score of 15 or above were entered on the corporate risk register which was monitored on a monthly basis by the risk management committee, all board level committees and the board of directors.
- Senior managers told us risks raised for the EOL service were on the community business group risk register and this was also stated in minutes from the September 2015 SPC governance meeting. The community healthcare risk register provided by the trust did not include any risks related to EOL services.
- A different, untitled risk register provided by the trust listed only one risk which was for EOLC and this related to a lack of resources needed to provide the education and training required to deliver the new EOLC training requirements. This risk was being managed, and the required changes to the service following the withdrawal of the LCP were being made, but they were in the early stages. In the meantime, there was a risk that care provided to patients at end of life may not be consistent across those areas where the IPOC was not yet in place.
- The lack of one comprehensive risk register for EOL services meant that potential risks may not be managed as effectively as they would be if they were being regularly reviewed as part of the risk register. For example, one issue flagged by the service but not included on the risk register was the gap in the level of EOLC consultant cover. The risk identified by Learning and Development concerning large numbers of staff being non-compliant with syringe driver training could also have an impact on EOL services but was not identified on their risk register.
- Mortuary and bereavement services were part of the cellular pathology department which in turn, was part of the laboratory medicine department within the

diagnostic and clinical support directorate. Divisional meetings were held once a month for three months, then every fourth month was a governance meeting. Monthly team meetings were also held by mortuary staff.
- Good practice in the mortuary included a comprehensive system for alerting staff where there were patients with the same or similar names. There were also systems and processes in place for when a body had to be stored for several weeks or months, including daily checks, weekly monitoring and bagging and transferal to a freezer after three weeks.

Leadership of service

- Staff received weekly updates from the chief executive and said the trust communicated to staff via emails which were cascaded at ward level.
- Ward staff on site at SHH said matrons conducted walk rounds and there were three matrons and the head of nursing who could be contacted when needed. Staff were not aware of routine visits from very senior staff.
- The palliative care consultant had quarterly meetings with the medical director which provided an opportunity to take EOLC matters directly to him.
- The manager of Bluebell Ward had recently started having monthly one-to-one meetings with her line manager; these were off site. The manager said she felt supported and the matron and head of nursing were at the end of the telephone and that she could and did contact them when needed. However, we saw no evidence that very senior staff had a regular presence on this ward.
- The post of mortuary manager was vacant at the time of our inspection, however the mortuary team were working well together, were knowledgeable about their systems and processes and were being well supported by senior pathology staff.
- Portering staff said their manager had a 'hands on' approach and was very supportive and visible.

Culture within the service

- There was a large display of thank you cards on Bluebell Ward and a bouquet of flowers arrived while we were visiting the ward from a family to thank staff for the care they had given to their relative . It was clear that many patients and families were very happy with the care delivered.
- Bluebell Ward had two link nurses for staff wellbeing who organised social activities and regular fundraising events. They had raised money for a number of charities including those supporting motor neurone disease and heart disease. They enjoyed these events and said they fostered good team spirit.
- There was an open and positive culture in the areas we inspected .Staff were proud to work in the service and overall felt supported by local management

Public engagement

- Surveys were carried out by the bereavement service at Beechwood cancer care centre and results from these were fed back directly to the wards by the EOLC facilitator which provided an opportunity for staff to respond to any concerns raised.
- The service had participated in the NCDAH and feedback from staff and patients had helped the service to improve the outcomes for patients.
- The public had online access to the minutes from the trust board meetings which provided information which may help the public understand about the hospital's performance.

Staff engagement

- Staff we spoke with were proud to work for the trust. One manager had worked there for 16 years and said that recent changes had resulted in increased support which motivated staff to "do well for the seniors" whereas previously they had just "muddled through".
- Staff spoke favourably about the annual Pride of Trust staff award scheme.

Innovation, improvement and sustainability

- The Stockport EPAC was being rolled out across the trust. Once fully implemented this will flag to the wards and departments if a patient has an EPAC record and therefore identified as being in the last year of life.
- Bereavement services were provided as part of a project undertaken through partnership between SHH and the Beechwood cancer care centre. This project commenced as a pilot in October 2012 and was being undertaken using existing funding from a bequest. However, despite funding being non-recurrent the sum donated was substantial, meaning the service could be sustained for the foreseeable future. In the longer term, work was ongoing to identify more permanent funding to secure the continuation of the service.

End of life care

- There was a tissue and organ donation committee which held quarterly meetings chaired by the medical director. The aims of this committee included the promotion of tissue donation, including the appointment of link nurses on the wards.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Outpatient services are provided from Stepping Hill Hospital and a number of community locations including Kingsgate House and Woodley Health Centre. There were a total of 368,420 outpatient attendances between July 2014 and July 2015. At Stepping Hill Hospital, outpatient clinics are held in two main departments, outpatients A and B. There are a number of smaller clinics, some of which provide more specialised care. These include the Laurel suite, Bobby Moore Unit, Lilac suite, Chest clinic and outpatient therapies. Some children are seen in other outpatient areas, for example Ear, Nose and Throat clinics, audiology, outpatients B and in radiology.

Diagnostic imaging services are provided at Stepping Hill Hospital from two departments, radiology A and B. Plain film x-ray and DEXA scanning is provided from radiology A and there are also two CT scanners located here. Ultrasound, mammography, nuclear medicine and interventional radiology is carried out at radiology B. MR scanning is carried out by an independent provider although this is based on the Stepping Hill site.

On our announced inspection on 19, 20,21, and 22 January 2016 we visited the following areas: outpatients A, B and C, Ear, Nose and Throat, the Lilac suite, the Laurel suite, Chest clinic, neurophysiology, outpatients therapies including the hydrotherapy pool, Bobby Moore Unit, audiology, cardiology ECG, the Marjory Warren unit, fracture clinic, pathology, radiology A and B. We also visited physiotherapy and cardiology at Kingsgate House. As part of our inspection, we observed care and treatment and looked at 17 sets of patient records. We spoke with 65 staff including nurses, doctors, consultants, support workers, managers, administrative workers and allied health professionals. We also spoke with 15 patients and carers using the services at the time of our inspection. We looked at information provided by the trust and other information we requested.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging as good in all domains, although effective was inspected but not rated, as we are not currently confident that we are collecting sufficient data to rate this domain.

We rated safe as good because:

- Staff were encouraged to report incidents. Lessons were learnt from incidents and these were shared openly with different staff groups. Duty of candour was understood and applied when necessary.
- Areas were clean and tidy. An 'I am clean' labelling system was in use. Regular audits were carried out to review infection prevention and control and hand washing. PCR testing had been introduced to speed up time from suspected clostridium difficile to test results.
- Equipment was checked and maintained correctly on most areas we visited. Medicines were stored correctly and only designated staff had access to medicines. Prescription pads and medical gases were stored safely.
- Records were a mixture of electronic and paper notes. Paper notes were stored securely. Staff logged off computer systems when not in use ensuring information security.
- Responsibilities and procedures in relation to adult and children's safeguarding were understood by staff. Adult safeguarding training had been undertaken to an appropriate level.
- Nursing staffing was organised to provide appropriate skill mix and numbers of staff. Bank workers received inductions which were documented.
- Radiology medical cover was provided 24 hours a day, supported by outsourcing of reporting. Locum consultants were used to supplement the current establishment.

However,

- In outpatients A the crash trolley was not checked in line with departmental policy.
- Although fridge temperatures were recorded, minimum and maximum temperatures were not logged.
- There were no staff with level three children's safeguarding training in adult outpatient areas that regularly ran clinics for children. Staff received training in mandatory topics although there were difficulties in accessing basic life support training in some areas so figures were low.
- There were five consultant radiologist vacancies at the time of our inspection and work was ongoing to fill these posts.

The effective domain was inspected but not rated, as we are not currently confident that we are collecting sufficient data to rate this domain.

- Evidence-based care and treatment was provided in line with national and local guidance. Services were audited locally and benchmarked against other local services.
- Staff were supported to maintain and develop skills and knowledge. Extended roles were encouraged and valued for both qualified and unqualified staff groups. Appraisal rates were generally more than 90% with some services achieving 100%.
- Teams worked well together to deliver effective patient care.
- Diagnostic imaging was available seven days a week, although inpatient MR scanning was not available at weekends. Outpatient clinics were not routinely held on evenings and weekends.
- Only two percent of patients were seen in outpatients without their full medical record.
- Staff understood the principles of consent and obtained consent correctly when required. Mental Capacity Act training had been received by over 90% of staff in Diagnostic and Clinical Services.

We rated caring as good because,

- Staff were kind, caring and compassionate. They were sensitive in their communications with patients and understood and respected individual needs. Privacy and dignity was maintained at all times in the clinical environment.
- Patients were involved in making decisions about their care and treatment. They were given information and time to ask questions.

Outpatients and diagnostic imaging

- Ninety percent of patients would recommend outpatients to their friends and family. In the Laurel suite this rose to 100%.
- Care in the Laurel suite and Bobby Moore Unit was outstanding. Patients we spoke with were very complimentary about the care and support they received.

We rated responsive as good because,

- Services had been planned and developed to meet the needs of local people and access to care was managed to take account of people's needs including urgent needs. There were a number of rapid access and drop in clinics. The Bobby Moore Unit ran a one-stop breast clinic service.
- Waiting times for diagnostic imaging and urgent cancer services were consistently below (better than) the national average and there were rapid access and drop in sessions five days a week in radiology.
- Patients were kept informed of any delays. They were able to leave the department and return later if delays were significant. Start times of clinics were monitored and incident reports were submitted if delays were long.
- In pathology, electronic reporting of results was available within 45 minutes within the trust and within half a day for primary care testing. Specialist advice was provided from pathology to other teams within one working day of the request.
- Individual needs were understood and considered when delivering services including dementia, learning disabilities, bariatric patients and the needs of children. Adjustments were made to enable these patients to access services. Staff received training in dementia awareness and there were three dementia champions in outpatients.
- Information about how to complain was available in the areas we inspected. Staff were able to give examples of complaints and how lessons had been learnt and changes made to working practices.

However,

- There were four specialities within the trust with high numbers of patients overdue a follow up outpatient appointment. There were plans to reduce the wait times for these patients but three of the specialities were behind the target set by the trust.
- In October 2015, 16.52% of patients waited for over 30 minutes before they saw a clinician. This rose to over 20% for some specialities.
- There had been a high number of complaints about outpatients A and B. Changes had been made in response to these but the service had not reviewed if these changes had been effective.

We rated well-led as good because,

- Staff were aware of the vision and strategy for the service. They understood and demonstrated the trust's values. Objectives were set in line with the trust's strategic aims and outcomes.
- Monthly and quarterly performance meetings were held. Radiology reviewed 10% of outsourced reporting to monitor quality. Audits were completed regularly in diagnostic imaging.
- The risk register was up to date and actions were taken to mitigate risks and reviewed regularly.
- Leaders ensured staff were informed and up to date through regular staff meetings. Staff at all levels told us that leaders were approachable and listened to suggestions or concerns. The culture was open and honest. Staff felt proud to work within outpatients and diagnostic imaging.
- Diagnostic imaging and outpatient therapies used patient satisfaction surveys and used information from these to improve services.
- There was evidence of planning to ensure sustainability of services including applications for investment in equipment. The diagnostic imaging service was taking positive steps to recruit radiologists and radiographers.

However,

- The outpatients department had not completed a patient satisfaction survey recently to gain feedback from service users.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff were encouraged to report incidents. Lessons were learnt from incidents and these were shared openly with different staff groups. Duty of candour was understood and applied when necessary.
- Areas were clean and tidy. An 'I am clean' labelling system was in use. Regular audits were carried out to review infection prevention and control and handwashing. PCR testing had been introduced to speed up time from suspected clostridium difficile to test results.
- Equipment was checked and maintained correctly on most areas we visited. Medicines were stored correctly and only designated staff had access to medicines. Prescription pads and medical gases were stored safely.
- Records were a mixture of electronic and paper notes. Paper notes were stored securely. Staff logged off computer systems when not in use ensuring information security.
- Responsibilities and procedures in relation to adult and children's safeguarding were understood by staff. Adult safeguarding training had been undertaken to an appropriate level.
- Nursing staffing was organised to provide appropriate skill mix and numbers of staff. Bank workers received inductions which were documented.
- Radiology medical cover was provided 24 hours a day, supported by outsourcing of reporting. Locum consultants were used to supplement the current establishment.

However,

- In outpatients A the crash trolley was not checked in line with departmental policy.
- Although fridge temperatures were recorded, minimum and maximum temperatures were not logged.
- There were no staff with level three children's safeguarding training in adult outpatient areas that regularly ran clinics for children. Staff received training in mandatory topics although there were difficulties in accessing basic life support training in some areas so figures were low.
- There were five consultant radiologist vacancies at the time of our inspection and work was ongoing to fill these posts.

Incidents

- Staff were encouraged to report incidents via an electronic reporting system. They told us that feedback about the outcome of incidents was given and learning was shared. Between 1 November 2014 and 31 October 2015, 597 incidents were reported. The majority of incidents reported were graded as minimal or moderate severity indicating there was a good reporting culture within outpatients and diagnostic imaging.
- The trust reported one never event relating to diagnostic imaging between October 2014 and November 2015, although the incident had occurred in April 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented. The never event related to a wrong site needle biopsy. We saw evidence that this never event had been thoroughly investigated and that steps had been taken to reduce the chance of similar events happening in the future. This included an updated adaptation of the World Health Organisation (WHO) safer surgery checklist. At the time of our inspection there was We were told that one of the actions from the investigation was still outstanding (the provision of a second PC in the interventional radiology room). We saw that all other actions had been completed.
- One serious incident was reported between October 2014 and November 2015. This incident was a diagnostic delay and investigations into this were ongoing at the time of our inspection.
- The diagnostic imaging service reported radiation incidents under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. These regulations place a duty on services to protect patients from harm. In 2015, 12 incidents were reported to the CQC. These incidents were a mixture of errors made by referring doctors, for example requests sent for the wrong patient, or by radiographer errors such as not checking

patient identification or the wrong x-ray factors on the equipment console. Incidents were reported to the CQC promptly and investigation reports were completed and shared.
- Duty of candour was understood by staff we spoke with and we saw evidence that the duty of candour regulation had been applied correctly. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.Leaflets explaining duty of candour were widely available.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. Domestic staff cleaned the outpatient and radiology departments out of hours to minimise disruption to appointments. An 'I am clean' labelling system was is use.
- We saw staff using personal protective equipment such as gloves and aprons to prevent the spread of infection. There were sufficient handwashing facilities and hand sanitiser dispensers available in all areas we visited. Recent handwashing audits showed 100% compliance in outpatients A, B and C and Bobby Moore Unit. In radiology A, the most recent audit we saw (9 October 2015) showed 95% compliance.
- We saw staff using the aseptic non-touch technique (ANTT). ANTT is a procedure used to prevent the spread of infection.
- Outpatient areas had 'practitioners in infection prevention' in place, who worked as link nurses with the infection prevention team.
- There was a protocol for the decontamination of equipment in the ENT department which was in line with best practice, with the use of clean and dirty rooms.
- Cleaning schedules were visible in some areas we visited (Marjory Warren, fracture clinic, outpatient therapies, lilac suite and ECG). We did not see any cleaning schedules for domestic staff in outpatients A. Cleaning audits for the week commencing 19 October 2015 showed 100% compliance in the chest clinic, Lilac suite and ECG. Results were lower in suite 2 and 3 (88% and 63%). Senior staff suggested that rooms had been cleaned but records not signed.
- Cleaning schedules for public toilets were not displayed, although these were clean and well maintained and there was advice on how to seek help if a toilet required cleaning.
- An infection prevention and control annual audit was undertaken in October 2015. This showed that overall the Laurel suite was 95% compliant Lilac suite and outpatients A were 81.4% compliant with the standards set down by the trust. Radiology A and B were both 79.1% compliant.
- The pathology department had introduced polymerase chain reaction (PCR) testing for suspected cases of clostridium difficile. This meant that results were turned around in one hour, allowing inpatients to be isolated or cohorted as quickly as possible to prevent the spread of infection.
- There were procedures in place in radiology to manage patients with known or suspected communicable diseases. Patients were scheduled at the end of the list and additional PPE was used, along with additional cleaning procedures.

Environment and equipment

- Emergency equipment was checked daily and weekly as per departmental policy in outpatients B, children's outpatients, the Laurel suite, Bobby Moore Unit and radiology B. In outpatients A, the crash trolley had not been checked in line with departmental policy. We saw that the trolley had not been checked on 32 days (Monday to Friday) between October and December 2015.
- In outpatients B, the main waiting area and corridors were carpeted. This meant that the department did not comply with Government guidance 'HBN00-09 Infection Control in the Built Environment'. We were told of one incident where staff had difficulty cleaning blood from the carpet following a patient fall. We also noted that the floor in the main waiting area was uneven in places.
- Equipment was maintained by the electro-biomedical engineering department (EBME), the onsite team responsible for maintenance and repairs. Staff told us how they reported equipment faults and that EBME were quick to respond. Specialist equipment in radiology A and B was monitored by Christie Medical Physics and Engineering. All equipment we checked had been serviced in line with requirements.
- Exposure to radiation was audited in radiology. Staff wore devices to monitor this radiation levels and the

results were received every two months via The Christie Hospital. Sufficient numbers of lead jackets and thyroid protectors were available. Access to non-ionising radiation areas was restricted via key code access and warning signs were displayed on doors.
- The dental department had recently been assessed by an external consultancy on the substances hazardous to health and found that levels of exposure to methyl methacrylate were well below the workplace exposure limit.

Medicines

- Medicines were stored appropriately in all areas we visited. Medicine cupboards and fridges were locked, with designated key holders having access to these storage areas. Controlled drugs were stored safely and correctly double signed.
- Allergy status was recorded on the electronic patient record. We observed clinicians checking allergy status prior to administration of medicines or applying dressings.
- Chemotherapy was delivered daily to the Laurel suite and stored in line with recommended procedures.
- Fridge temperatures were checked and recorded daily. We noted that maximum and minimum temperatures were not recorded. This meant that staff would not know whether fridges had been operated out of the correct temperature range. However, we did not find any evidence to suggest that this had happened.
- Pharmacy technicians checked stock and expiry dates weekly in outpatient areas. Staff at physiotherapy at Kingsgate House told us that this check was completed weekly by administrative staff, although this was not formally recorded.
- Prescriptions pads were stored appropriately. There was a system in place to ensure security of prescription pads including double locking and double signatories.
- We saw that medical gases were stored safely and securely in all areas we visited.
- Outpatient prescriptions were dispensed by a pharmacy subsidiary company. This pharmacy was open Monday to Friday 9am until 6pm.

Records

- Main outpatient areas used an electronic record system. Clinical notes were written on paper medical notes sheets which were then scanned into the electronic system following the appointment. Clinical letters were dictated by the medical team reading for typing by secretaries. Where paper notes were used, these were supplementary to the information provided on the electronic record. Paper records were stored in locked cupboards or rooms when not in use.
- Two per cent of patients were seen in outpatients without their full medical record being available during 2014/15, however, clinicians had access to previous clinic letters via the electronis record system.
- Diagnostic images were stored electronically on a picture archiving and communication system (PACS). This allowed images to be reviewed remotely and at different hospital sites.
- Outpatient therapy and physiotherapy at Kingsgate House used paper records. These records were complete and stored appropriately.

Safeguarding

- Staff were aware of their responsibilities in relation to adult and children's safeguarding. They were able to tell us where to gain advice and how to make a safeguarding referral. The safeguarding team were available for advice during normal working hours.
- Ninety-four percent of staff in Diagnostics and Clinical Services (DCS) had completed safeguarding adults level two training. Safeguarding children level two completion rates were high at 96.57%.
- Senior nurses told us that they ensured staff working in areas outside of children's outpatients where children were regularly seen such as ear, nose and throat (ENT) had received level three children's safeguarding training. Training figures received from the trust showed that no nurses based in adult outpatient areas had received level three training. We raised this concern with at the time of our inspection and the trust told us this was in line with trust policy.
- One radiographer had received level three training, along with two occupational therapists and five physiotherapists.
- In interventional radiology, an adapted version of the World Health Organisation Surgical Safety Checklist was in use. This had been updated following an investigation into the never event. A safety huddle was also used prior to any interventional procedure. An audit in November 2015 showed that the WHO checklist had been used in 100% of interventional procedure case

notes. There were a number of improvements in documentation identified from this audit, such as the documentation of the patient's hospital number but overall the audit risk was low.

Mandatory training

- Overall mandatory training rates for DCS was 94.97% which was just below the trust target of 95%. Basic life support training was low at 80.6%. We were told by two separate staff groups that accessing basic life support training had been difficult.

Assessing and responding to patient risk

- Outpatient staff told us that there was a procedure in place for admitting patients from clinic if this was required. If a patient became acutely unwell with an unrelated medical problem and required urgent medical attention, the patient was accompanied to accident and emergency.
- In the Laurel suite, toxicity assessments were undertaken for each cycle of chemotherapy and patients were observed in line with national guidance. Patients were given an out of hours contact plan that had clear information as to who to contact if they had any concerns.
- An early warning score system was in use for patients undergoing intervention radiology procedures. This allowed nurses to monitor any deterioration and take appropriate action if a patient became unwell.
- Radiology had procedures in place for rapid notification of 'red flag' findings for cancer and unexpected non-cancer findings to ensure results were communicated quickly to the relevant team.
- Waiting lists for patients who were overdue follow up appointments were being monitored to ensure that patient safety was not being compromised. For example, there were no high risk patients with conditions such as glaucoma or diabetic retinopathy overdue appointments.

Nursing staffing

- An acuity tool had not been used to calculate nursing staffing. Rotas were prepared four weeks in advance based on numbers of clinics taking skill mix into account and stored electronically. Senior clinicians made changes to rotas when needed, for example staff sickness or where additional clinics had been added. Where possible, staff were allocated to clinics based on gender when this was considered necessary.
- Outpatients A and B were each staffed by two band five registered nurses (RNs). One of these nurses co-ordinated the outpatient areas and the second nurse was designated as the 'quality nurse'. The quality nurse supported outpatients C, the Bobby Moore Unit and the Lilac suite where clinics were co-ordinated by unregistered nurses, as well as carrying out other specified duties such as equipment checks and quality measurement.
- Clinics in the Lilac suite were co-ordinated by a band two support worker which was a high level of responsibility for this banding of staff, although support was available from the band five quality nurse.
- There were designated RNs work in ENT and fracture clinic
- The Bobby Moore unit was co-ordinated by a band four support worker, supported by a band three and band two support workers. This unit was staffed to ensure chaperones were available at all times.
- The outpatient areas used NHS professional staff to support staffing shortages, sickness or additional clinics. Induction checklists were completed for new staff.
- There was a RN vacancy rate of 12.46%and unqualified nursing staff rate of 1.69%.

Medical staffing

- A consultant radiologist, or a specialist registrar supported by a consultant radiologist were on call over-night, at weekends and bank holidays. Emergency reporting was out-sourced to an external tele-reporting agency between 10pm and 9am. This ensured that the consultant on-call was available for on-site work if this was required.
- There were five consultant radiologist vacancies at the time of our inspection. Two consultant radiologists had recently been appointed to these posts. Three locum radiologists were supporting the delivery of diagnostic imaging services alongside permanent staff. Between December 2014 and December 2015 the locum usage rate was 21.8%.
- Laboratory medicine cover was provided 24 hours a day. Vacancy rates were low at 3.19%.

Outpatients and diagnostic imaging

- Routine reporting of electroencephalograms (EEGs) was carried out by a visiting consultant. Urgent EEGs were reported via liaison with consultant neurologists at Salford Royal Hospital.

AHP Staffing

- The overall trust allied health professionals (AHPs) vacancy rate was 12.25%. Integrated therapies were split into teams with an appropriate level of skill mix.
- In radiography, the vacancy rate was 10.61%. There were two WTE vacancies for sonographers. Sonographer cover was supplemented by staff from a private agency on Saturdays, Sundays and evenings.
- There were six WTE radiographer vacancies. Two new radiographers had been recruited. The department used locum and bank staffing to supplement the current establishment.

Major incident awareness and training

- There were business continuity plans in place for each of the outpatient areas we visited. These included contingency plans to be used in the event of staffing shortages and equipment failure.
- There was a trust wide 'Emergency Preparedness and Business Continuity Management Policy'.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain was inspected but not rated, as we are not currently confident that we are collecting sufficient data to rate this domain.

- Evidence-based care and treatment was provided in line with national and local guidance. Services were audited locally and benchmarked against other local services.
- Staff were supported to maintain and develop skills and knowledge. Extended roles were encouraged and valued for both qualified and unqualified staff groups. Appraisal rates were generally more than 90% with some services achieving 100%.
- Teams worked well together to deliver effective patient care.
- Diagnostic imaging was available seven days a week, although inpatient MR scanning was not available at weekends. Outpatient clinics were not routinely held on evenings and weekends.
- Only two percent of patients were seen in outpatients without their full medical record.
- Staff understood the principles of consent and obtained consent correctly when required. Mental Capacity Act training had been received by over 90% of staff in Diagnostic and Clinical Services.

Evidence-based care and treatment

- Diagnostic imaging followed national guidelines to prioritise patients based on clinical need. Category A included stroke patients with potential for thrombolysis and urgent scans for patients involved in road traffic accidents. NICE guidelines for the reporting of images were followed.
- Policies and procedures were in place locally. Radiology had guidelines in place for the use of contrast media and to reduce the risk of contrast induced nephropathy. These guidelines followed evidence-based practice.
- Guidelines produced by professional bodies such as ENT UK, the Chartered Society of Physiotherapists and NICE guidelines for the management of cardiovascular conditions, diabetes and chronic obstructive pulmonary disease (COPD) were followed.
- We saw poster presentations showing evidence that staff considered evidenced-based treatment in areas such as outpatient therapies, interventional radiology and pathology.

Pain relief

- Pain and pain relief was discussed when required during outpatient consultations.
- Pain relief was administered in a timely way in interventional radiology.
- There was a standard operating procedure for the use of sedation in the dental department.

Equipment

- Access to specialist equipment was good. For example, there were three ECG machines in outpatients B for use in cardiology clinics.

Outpatients and diagnostic imaging

- Staff told us that there were some difficulties in accessing additional equipment to improve the flow of patients in departments. For example, in cardiology ECG a second analyser could not be obtained due to financial constraints.
- During our inspection, one CT scanner stopped working during a scan. The decision was made to stop using this scanner until maintenance could be completed.

Patient outcomes

- Diagnostic imaging regularly carried out audits to review practice. These included compliance with NICE guidance on the management of head injury, thyroid fine needle aspirations and ultrasound in acute kidney injury.
- Diagnostic imaging had established protocols for the reporting of films. Urgent and emergency scans were reported as soon as possible, to allow the treating medical team to commence treatment quickly. Scans were then more closely analysed, with any additional and more in-depth findings reported.
- The diagnostic imaging service was not participating in the Imaging Services Accreditation Scheme (ISAS). ISAS acts as a mark of quality and takes approximately 18 months to achieve.
- The physiotherapy department measured patient outcomes using the EQ5D, a measure of health outcomes. They also used a modified goal attainment scale (M-GAS) to monitor achievement of patient goals.
- The spinal service in outpatients used the Oswestry Disability Questionnaire was used by the spinal service
- Neurophysiology team regularly benchmarked their services with other local teams to ensure the quality of the service and reporting.

Competent staff

- Staff were supported to develop extended skills in outpatients and diagnostic imaging, including both qualified and unqualified staff. This included NVQ training for unqualified staff.
- Extended roles were used in outpatients including advanced dressing techniques in fracture clinic, issuing of orthotic devices and plaster technicians. Competency packs had been developed to ensure staff had the necessary skills to carry out these extended roles.
- There were a number of nurse practitioners and extended scope physiotherapy practitioners within outpatient departments. There were nurses who had undertaken the non-medical prescribing course and a prescribing pharmacist had a role in rheumatology and oncology clinics.
- In diagnostic imaging, there were a number of radiography staff with extended skills. These included CT head reporters, extended scope practitioners in x-ray reporting and in barium imaging.
- There was a well-established preceptorship programme in the therapy department. In house training was provided to share skills and knowledge within the department.
- A specific competency programme was in place for radiographers to demonstrate they were skilled to work within the interventional radiology suite. Monthly in house training sessions were available.
- In the Laurel Suite and physiotherapy at Regent House, 100% of appraisals had been completed as at December 2015. For AHP outpatients the rate was high at 98.4%. Appraisal rates were lower in radiology (91.4%), outpatients (92.93%) and on the Marjory Warren Unit (80%).
- Staff told us they felt supported when starting work within the departments or taking on new roles. In neurophysiology and outpatient therapies, staff received regular formal supervision.
- Further academic study was supported and we saw evidence that learning from this was shared.
- There were some difficulties in accessing specialist external training due to financial constraints. Staff told us that this was sometimes managed by the trust agreeing study leave and staff funding courses themselves.

Multidisciplinary working

- There were close relationships between the Bobby Moore Unit, Laurel suite and The Christie Hospital.
- The radiology team were part of the cancer MDT and formed part of the cancer quality board alongside colleagues from the hospital and primary care.
- In the pain clinic, one patient told us there had been difficulties with communication between the different health professionals involved in his care including passing on results from the privately run scanning unit.

Seven-day services

Outpatients and diagnostic imaging

- Outpatient clinics were offered on Saturdays and evenings for some specialities. Some of these clinics were additional clinics as part of a waiting list initiative rather than the norm. Outpatient therapies did not offer weekend appointments.
- Pathology services were provided 24 hours a day, seven days a week.
- There were three radiographers on site 24 hours a day, seven days a week to provide plain film x-rays, mobile x-rays, CT scans and theatre imaging. One of these radiographers is trained in reporting CT head scans. Non-obstetric ultrasound was offered at weekends provided by a private organisation, supported by in-house radiology assistants.
- Interventional radiology was available 24 hours a day. The exception to this was if the radiologist on call was not skilled in urological intervention. We were told this had not been an issue in the past and if this problem arose, a transfer to a local hospital would be agreed.
- There was no provision for inpatient MR scanning over the weekend. If an inpatient required an urgent MR scan at the weekend, there was an agreement with Salford Royal Hospitals NHS Trust to transfer the patient for the scan and then return to Stepping Hill.

Access to information

- Two per cent of patients were seen in outpatients without their full medical record being available during 2014/15. The trust told us that all possible actions were taken to locate patient notes and that incident reports were completed when medical records were not available. The availability of case notes was routinely audited in outpatients.
- Routine clinic letters were sent within one week. There was scope for urgent letters to be completed and sent the same day.
- There was electronic access to diagnostic results and images throughout the Greater Manchester area. The exception to this was imaging completed a Buxton Cottage Hospital. We were told that if it was not possible to obtain copies of x-rays, in some instances a second x-ray would be taken.
- Diagnostic imaging results were available to GPs within two working days. Urgent or unexpected findings were communicated immediately to the referring clinician.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff taking verbal consent and written consent when this was required. Written consent was undertaken by appropriately skilled staff and was stored correctly in patient records. Copies of consent were given to patients.
- In DCS, 90.15% of staff had received training on The Mental Capacity Act.
- In physiology, additional information was provided to patients attending from care homes.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because,

- Staff were kind, caring and compassionate. They were sensitive in their communications with patients and understood and respected individual needs. Privacy and dignity was maintained at all times in the clinical environment.
- Patients were involved in making decisions about their care and treatment. They were given information and time to ask questions.
- Ninety percent of patients would recommend outpatients to their friends and family. In the Laurel suite this rose to 100%.
- Care in the Laurel suite and Bobby Moore Unit was outstanding. Patients we spoke with were very complimentary about the care and support they received.

Compassionate care

- Privacy and dignity was maintained at all times in the areas we visited. Staff respected people's personal, cultural and religious needs and gave choices regarding care and treatment.
- In radiology B, we saw that staff had very carefully considered the needs of patients attending from the one stop breast clinic and ensured a high level of privacy and dignity for this patient group.
- Reception staff were friendly and helpful, although there were no facilities to prevent patients from being overheard at the reception desk.

Outpatients and diagnostic imaging

- Personalised, patient centred care was offered in the Laurel suite. This service was holistic and offered links to other services for additional support. Staff understood the emotional and spiritual needs of patients and gave these needs high priority.
- Chaperones were provided at all times on the Bobby Moore Unit and were available as required in other clinics. Staffing was arranged to provide same gender chaperones as much as possible.
- Staff were kind, patient and considerate of people's needs. They were sensitive and supportive in their communication with patients.
- Feedback from patients we spoke with was very positive. They told us staff were very friendly, approachable and gave them time to discuss any particular needs.
- Overall for outpatients, 90% of people would recommend the service to their family or friends although response rates were low.

Understanding and involvement of patients and those close to them

- Patients were treated as partners in their care. Staff ensured information about care and treatment was provided and understood. They recognised when additional support or time may be needed. We observed patients and their carers being given information about their care and treatment and offered time to ask questions and patients told us they understood their planned care and treatment.
- We saw that patient information leaflets were available in outpatient areas we visited. These included leaflets produced by charity groups and by the trust.
- In the Laurel suite, a discharge pack with further information about chemotherapy had been compiled following feedback from patients. Patients spoke very highly of the care they received from all team members. They described being given the time they needed to ask questions and staff as "brilliant" and "very knowledgeable". Family and friends test results showed that 100% of patients would recommend the Laurel suite.
- Patients were sent clinic letters following their appointments to ensure they were kept informed about the outcomes and future treatment plans. In some areas, additional information was sent to patients explaining what to expect at their clinic appointment.

Emotional support

- There were a number of clinical nurse specialists available to offer additional emotional support to patients. These included stoma nurses, breast care nurses, COPD nurses, children's diabetes nurses and rheumatology nurses.
- Emotional support on the Laurel Suite and Bobby Moore Unit was outstanding. Personalised, patient centred care was offered in the Laurel suite. This service was holistic and offered links to other services for additional support. Staff understood the emotional and spiritual needs of patients and gave these needs high priority.
- The audiology team provided a tinnitus counselling service for patients.
- Nurses in interventional radiology offered additional support providing a follow up telephone call one month later.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because,

- Services had been planned and developed to meet the needs of local people and access to care was managed to take account of people's needs including urgent needs. There were a number of rapid access and drop in clinics. The Bobby Moore Unit ran a one-stop breast clinic service.
- Waiting times for diagnostic imaging and urgent cancer services were consistently below (better than) the national average and there were rapid access and drop in sessions five days a week in radiology.
- Patients were kept informed of any delays. They were able to leave the department and return later if delays were significant. Start times of clinics were monitored and incident reports were submitted if delays were long.
- In pathology, electronic reporting of results was available within 45 minutes within the trust and within half a day for primary care testing. Specialist advice was provided from pathology to other teams within one working day of the request.
- Individual needs were understood and considered when delivering services including dementia, learning

disabilities, bariatric patients and the needs of children. Adjustments were made to enable these patients to access services. Staff received training in dementia awareness and there were three dementia champions in outpatients.
- Information about how to complain was available in the areas we inspected. Staff were able to give examples of complaints and how lessons had been learnt and changes made to working practices.

However,

- There were four specialities within the trust with high numbers of patients overdue a follow up outpatient appointment. There were plans to reduce the wait times for these patients but three of the specialities were behind the target set by the trust.
- In October 2015, 16.52% of patients waited for over 30 minutes before they saw a clinician. This rose to over 20% for some specialities.
- There had been a high number of complaints about outpatients A and B. Changes had been made in response to these but the service had not reviewed if these changes had been effective.

Service planning and delivery to meet the needs of local people

- A one-stop breast clinic service was offered in the Bobby Moore Unit in conjunction with the radiology B area. This meant that patients referred to the service could have consultations with the medical team and any necessary investigations carried out in one visit to the hospital.
- On the Marjory Warren Unit, the rapid access stroke clinic was able to see patients with 24 to 48 hours. Patients were triaged via a GP referral system and referred on to therapists as required. The service aimed to complete all investigations on the same day and make all relevant referrals.
- New clinics had been developed in cardiology ECG including stress echo testing and valve surveillance clinics.
- In January 2015, radiology had introduced a new system of direct booking for suspected cancer patients. When an imaging request was made at the patients first outpatient appointment, the patient was referred directly to radiology where the appointment was arranged and any preparation or instructions were given. This prevented delays in posting appointments or potential cancellations.
- In outpatients A and B, there was a café where patients could purchase drinks, snacks and newspapers.

Access and flow

- The did not attend (DNA) rate for outpatients at Stepping Hill Hospital was 8%. In radiology, the DNA rate was between 3 and 4%
- Data showed that follow up to new appointment rates were similar to the England average at Stepping Hill.
- The trust had failed to meet the standard of 95% for non-admitted referral to treatment rate and had been worse than the England average between October 2014 and September 2015.
- Diagnostic waiting times had been consistently lower than the England average between November 2013 and September 2015. There were rapid access and drop in clinics scheduled five days a week in radiology.
- The trust had performed consistently better than the England standard for incomplete pathways referral to treatment times between October 2014 and September 2015.
- The trust had performed better than the England average for the percentage of patients seen within two weeks for urgent cancer referrals and for patients receiving their first definitive treatment within 62 days.
- There were four specialities within the trust with high numbers of patients awaiting follow up appointments who were past their due date. These were ophthalmology (211 patients overdue), gastroenterology (1892), respiratory medicine (287) and cardiology (53). There were plans in place to reduce these numbers, but gastroenterology, ophthalmology and respiratory medicine were behind the targets set by the trust. This was being monitored by the quality assurance committee (a sub-committee of the board of directors) and performance was being shared with the board via the integrated performance report. At the time of our inspection the trust was being closely monitored by the clinical commissioning group and was expected by the CCG to complete a quality impact assessment to ensure patient care was not being compromised.
- Between July 2015 and October 2015 4.75% of clinics were cancelled less than six weeks before the

appointment and 3.75% were cancelled more than six weeks before. The main reasons for cancellations were given as sickness, annual leave and a template change (change in clinic times or location).

- Clinics were a mixture of new and follow up appointments. New patients were usually given a 30 minute appointment with 10-15 minute follow up appointments.
- The trust reported that 16.52% of patients waited for over 30 minutes before they saw a clinician during October 2015. More than 20% of patients attending paediatrics, neurosurgery, nephrology, ENT and chest clinic appointments waited over 30 minutes.
- The trust operated a number of rapid access or drop in clinics at Stepping Hill hospital. These included a breast drop in service, colorectal drop in, rheumatology drop in and rapid access ENT service. These clinics ensured that patients could easily access advice and support from these services. The ENT rapid access service reduced pressure on the emergency department and primary care services.
- There was a procedure in place in outpatient areas to inform patients of any delays. Waiting times were displayed on white boards for each clinic and staff made announcements every 30 minutes to ensure patients were updated on how long they may expect to wait. Staff told us that when delays were long, they apologised to patients and took mobile phone numbers to allow patients to leave the department for fresh air or a drink. They would then contact the patient to return back to the department. In the chest clinic, pagers were available.
- A triage system was in place for outpatient physiotherapy. Patients were triaged into categories (urgent, as soon as possible and routine) with waiting times attached to these. There was a two week wait for audiology appointments.
- In pathology, electronic reporting of results was available within 45 minutes within the trust and within half a day for primary care testing. Specialist advice was provided from pathology to other teams within one working day of the request.
- Clinic start and finish times were monitored and reasons for delays documented. These were reviewed by the band six nurse and logged. Incident forms were completed when significant delays occurred. Data provided by the trust showed to 10.65% of clinics started late.
- Fracture clinic prioritised patients in accident and emergency and inpatients to ensure flow of patients in these areas.
- Staff told us that delays for x-ray in radiology A could lead to further delays in fracture clinic and in chest clinic. Medical staff aimed to see patients within 30 minutes after returning from x-ray. If patients were unable to wait, they were offered the opportunity to book an appointment in x-ray and return on another day. Some delays were due to equipment failure.
- In outpatients C, patients were given instant INR results and any medication adjustments were completed by the band six doser nurse.
- Senior nurses in outpatients told us that the departments were very busy and full to capacity. An electronic clinic booking system was used to co-ordinate clinics.
- Patients, carers and staff told us that parking on the Stepping Hill site was a particular problem. Patients worried about being able to find a parking space and often spent a long time looking for a space. Frequently, family members or carers had to leave patients at an entrance to attend their appointments alone until a sparking space could be found. Staff told us that it was a common complaint and patients would attend departments and express their concerns.
- At busy times in Lilac suite, staff told us there were not always enough seats in the waiting room to accommodate all patients.

Meeting people's individual needs

- The trust had a matron for dementia in place who offered local support to outpatient areas. There was a trust wide dementia strategy. Link nurses were in place in the Marjory Warren Unit, where patients were referred for memory tests.
- The trust has access to a register via the local authority to identify patients with learning disabilities. This information is added to the patients' record and can also be added manually. One member of staff in the Laurel suite had received a good practice recognition of care for her work with a patient with a learning disability undergoing treatment for cancer.
- Two mammographers had delivered sessions at a local GP surgery for patients with learning disabilities or mobility problems about the importance of breast screening and what happens when they attend in order to increase the uptake in this patient group.

Outpatients and diagnostic imaging

- In outpatients, 80% of nursing staff had attended additional dementia awareness training run by Stockport Dementia Care Training, delivered in part by people living with dementia. There were three dementia champions within the department. The aim was for 100% of staff to attend this training.
- Staff told us that appointments for patients with dementia or a learning disability could be brought forward if there was a long waiting time. They were also able to offer a quiet room to wait in if the patient was becoming distressed.
- In ENT, staff had received training in extended communication skills and breaking bad news to support patients pre and post head and neck surgery.
- Translation services were available for patients whose first language was not English. This was either face to face or via telephone consultations. Staff told us that patient information leaflets produced by some charities were available in other languages. Trust produced information leaflets advertised the availability of interpreting services that could interpret written information if required.
- There were checklists in place to consider the needs of bariatric patients and an agreement with an inpatient ward to support with manual handling or hoisting if this was required.
- The audiology team were able to visit patients on the ward if required. They also carried out home visits to reduce the need for patients to travel by ambulance as delays in ambulance transport had adversely affected their ability to run to time in clinics.
- In some outpatient waiting areas, there was limited choice of different seating to meet the needs of patients with mobility difficulties.
- A recent change in the referral process for hearing aids meant that patients often had to attend the hospital twice. Staff told us that the inflexibility of audiology appointment system could also result in the need for children to attend the hospital twice.

Learning from complaints and concerns

- Leaflets explaining how to raise a complaint or concern were available in the waiting areas we visited.
- The radiology team held monthly discrepancy meetings to discuss cases, identify actions and highlight learning points.
- When looking at complaints by location we saw that outpatients A had the second highest number of complaints throughout the trust and outpatients B had the fourth highest. There had been 194 formal and 73 informal complaints for DCS during 2014-15. The main complaints themes were clinic delays or cancellations, staff attitude and communication. Changes had been made to improve the provision of information about clinic delays, although the impact of these changes had not been reviewed.
- Staff were able to give examples of how the service or practice had changed in response to complaints. These changes included gowns that provided more dignity and changes in administrative systems for sending letters.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because,

- Staff were aware of the vision and strategy for the service. They understood and demonstrated the trust's values. Objectives were set in line with the trust's strategic aims and outcomes.
- Monthly and quarterly performance meetings were held. Radiology reviewed 10% of outsourced reporting to monitor quality. Audits were completed regularly in diagnostic imaging.
- The risk register was up to date and actions were taken to mitigate risks and reviewed regularly.
- Leaders ensured staff were informed and up to date through regular staff meetings. Staff at all levels told us that leaders were approachable and listened to suggestions or concerns. The culture was open and honest. Staff felt proud to work within outpatients and diagnostic imaging.
- Diagnostic imaging and outpatient therapies used patient satisfaction surveys and used information from these to improve services.
- There was evidence of planning to ensure sustainability of services including applications for investment in equipment. The diagnostic imaging service was taking positive steps to recruit radiologists and radiographers.

However,

Outpatients and diagnostic imaging

- The outpatients department had not completed a patient satisfaction survey recently to gain feedback from service users.

Vision and strategy for this service

- Staff we spoke with understood the trust vision and strategy. They were able to tell us about the values. The trust's valued-based behaviours were displayed in the areas we visited. These were a set of behaviours developed with patients and staff that were expected from staff working at Stockport NHS Foundation Trust.
- Outpatients and diagnostic imaging services had set objectives in line with the trust's strategic aims and outcomes. These were aligned to the 'Two Year Ambition' of improved patient engagement, every contact counts, improved productivity, resilient teams and innovative/support pathways.

Governance, risk management and quality measurement

- Monthly quality and performance meetings were held for diagnostics and clinical support services. These meetings were based around a standard agenda template. Outpatient managers and senior staff held weekly meetings to discuss issues arising.
- In radiology, monthly meetings were held to discuss incidents, concerns and to share learning. The radiology clinical service lead along with the modality leads meet with the consultant body quarterly. There was a designated band seven clinical governance facilitator who investigated all incidents and complaints.
- Radiology consultants reviewed 10% of reporting completed by the outsourced private company to ensure quality standards were met. There was an audit lead within radiology
- Risk registers were complete and updated. Actions taken or planned to mitigate risks were documented and review dates were set.

Leadership of service

- Outpatients and diagnostic imaging were managed under the diagnostic and clinical support services group. There was a director for the business group and there were two joint clinical directors of radiology.
- Outpatients held a monthly staff meeting which covered all outpatient areas. These meetings were minuted and these minutes were available in the staff room. Staff meetings included updates on clinical and on governance issues.
- There had been recent changes within outpatients leadership and management. We were told these changes had been positive for the service and staff.
- The director of clinical and diagnostic services us that there were weekly meetings with the associate medical director and medical director and fortnightly meetings with the director of operations. She was supported by a dedicated human resources manager. The chief operating officer was involved in monthly cancer breach meetings.
- Staff at all levels told us that they felt leaders were open to listening to concerns and that concerns were considered seriously.
- We were told about succession planning in fracture clinic. Leaders anticipated change and put plans into action to reduce the risk of a gap in staff skills.
- In outpatient therapies, services had been integrated to include all allied health professionals. Staff told us that this integration had been successful between occupational therapy and physiotherapy but had been less successful with dietetics and speech and language therapy.

Culture within the service

- There was an open and honest culture within the services we inspected. Staff told us they were happy in their jobs and would recommend the trust as a place to work.
- In the Bobby Moore Unit and on the Laurel suite, staff told us they were very proud to work within these services. In neurophysiology, staff told us there was amazing team spirit and they felt well supported.
- For the period January 2015 to December 2015 in radiology AHP staffing sickness rate was 3.68% and outpatient therapies was 3.54%. Sickness rates in these areas were below the trust target of 4%. In outpatients, sickness rates for nursing staff was above the trust target at 6.75%.

Public engagement

- Friends and family test information and comments were displayed in outpatient areas we visited.

Outpatients and diagnostic imaging

- Outpatient therapies and diagnostic imaging used patient satisfaction surveys to gain feedback about the service they offered. Good practice was shared in team meetings and actions were taken to make improvements. Outpatients had not completed a patient satisfaction survey since 2014.
- We saw comments cards and boxes in many areas we visited.

Staff engagement

- Staff told us about an annual event held by the executive team to summarise performance over the previous 12 months and plans for the following 12 months. They spoke positively about this event.
- Staff were encouraged to make suggestions about services and were involved in service improvements.

Innovation, improvement and sustainability

- Radiology department had identified actions required for service improvement and sustainability. The second CT scanner was due to be decommissioned at the end of February with a new scanner being in place by the end of 2015/16. Plans had been made to use a mobile CT scanner for the period between decommissioning and installation of the new CT scanner. A second MR scanner had been negotiated as part of the service level agreement with the private scanning company to ensure the service could continue to meet current and future demand for scanning services
- The directorate recognised the difficulties of recruiting radiologists due to a national shortage and were taking steps to recruit from overseas.
- The diabetes service had improved the quality of their patient's journey and care by enabling electronic data transfer of insulin pumps. This meant that consultants had the maximum, most up to date data at outpatient appointments and promoted patient empowerment.
- There was an electronic booking system in use in outpatients that maximised efficiency of the usage of clinic rooms and allowed services to book clinic areas electronically. The system was integrated, providing email confirmation of room bookings and notifying the outpatient booking team to allow them to begin making appointments.

Outstanding practice and areas for improvement

Outstanding practice

- The introduction of PCR testing for clostridium-difficile ensured rapid results were available to medical teams to reduce the potential spread of infection within inpatient areas.
- Care on the Laurel suite and on the Bobby Moore Unit was outstanding. Staff were strongly person centred and understood and respected the totality of patient's needs. They involved patients as partners in their care and provided high levels of emotional support.
- In the hyper acute stroke unit; we observed outstanding practice; where patients were assessed and treated rapidly by competent specialists. This increased their chance of treatment and ultimately maximised their chance of recovery from a stroke.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

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 patient manual handling.
- 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 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 the trusts internal escalation policies are followed appropriately.
- Ensure that there is an adequate policy or procedure to guide the practice of 'boarding' to ensure patient safety.
- Ensure that all risks identified in relation to the emergency department are appropriately risk assessed and appropriate control measures are in place.

Medical Services (Including Older People services)

- Ensure that number of times a patients moved is minmal and is only for clinical reasons.
- Ensure that patients are discharged to their appropriate place of care when medically fit to do so.
- Ensure that records trollies are kept locked when unattended to ensure they are not accessible to the general public.
- Ensure the agreed establishment of qualified nurses are employed in the medical division

Critical Care

- Ensure that the practice of pre-filling syringes with intravenous medicines and then storing them in the

Outstanding practice and areas for improvement

fridge is not continued. For any scenario where a clinical decision results in this practice being reconsidered, then a detailed risk assessment should be undertaken, which should include the involvement of the critical care pharmacist.

Maternity and Gynaecology

- Ensure all staff are up to date with adult basic life support training
- Ensure there is a system in place to learn and share learning from incidents.
- Ensure all steps of the safer surgery checklist are completed for all surgical procedures in the obstetric theatre.
- Ensure a system is in place to monitor patient outcomes against set local or national targets.
- Ensure midwives are up to date with skills and drills training
- Ensure midwives assisting the anaesthetist in the obstetric theatre are trained in line with national guidance.
- Ensure there is a system for continuous monitoring the quality of the service provided and make necessary improvements.

Children and Young People

- Ensure there is a senior staff member on each shift on the paediatric unit.
- Ensure there is a staff member that is HDU trained on each shift on the paediatric unit.
- Ensure the door exit systems on the paediatric and neonatal unit are secure.
- Ensure staff members' medications are securely stored and do not include the trust's generic medications.
- Ensure that fridge temperatures are regularly checked, documented and acted upon in accordance with the trust's policy and procedures.
- Ensure all staff working with children and young people have level three safeguarding training.

In addition the hospital should:

Urgent and emergency care

- Ensure that there is an adequate provision of equipment used for resuscitation in all areas of the emergency department.
- Ensure patients are offered food and drinks where clinically advised by staff members
- Ensure that staff within the emergency department receive their annual appraisals
-

Surgery

- Ensure the standardisation of defibrillators across the trust to comply with Resuscitation UK guidelines.
- Enusre the procedures for checking of resuscitation equipment and whether this is now a daily or monthly check to ensure consistency between wards.
- Ensure that all resuscitation trolleys are sealed at all times when not in use. They should also ensure that when they are checked and re-sealed the relevant unique reference number recorded for safety and audit purposes.
- Ensure that there is compliance in with the medicines administration policy concerning the recording of wastage of controlled drugs that have not been used.
- Ensure the policy regarding storage of IV medicines which are not in a recognised medicines cabinet, to ensure this complies with RPSGB guidance.
- Ensure their policy and procedures concerning PGD and ensure staff awareness in light of new electronic prescribing practice.
- Ensure that patient records are stored securely and cannot be accesses by non-designated persons.
- Ensure steps to improve compliance with mandatory training and improve recording and accuracy of compliance are taken.
- Ensure compliance with staff annual appraisal targets are achieved .

Critical Care

- ensure that all staff receive training on the principles of Duty of Candour.
- ensure that work continues to improve the access and flow in the department and improvements are made to the issue of delayed discharges.
- ensure that nutritional supplements are not stored in the visitors kitchen
- consider how it is going to meet the requirements of the latest health building notes guidance in any future expansion of the critical care service.

Maternity and Gynaecology

- Ensure that improvement in the assurance that all emergency equipment is in full working order at all times.

Outstanding practice and areas for improvement

- Ensure input from the pharmacy department for the management of medicines on the maternity services.
- Ensure there is a system in place to monitor improvements identified during through audits.
- Ensure sufficient specialist midwifery cover to support patients with additional mental and physical health needs is provided.
- Ensure I times against the national 2 week cancer referral to treatment targets areimproved .

Children and Young People

- Ensure there is supernumerary co-ordinator on the neonatal unit in accordance with BAPM guidance.
- Ensure there is a staff member with APLS training on each shift on the paediatric unit.

End of life care

- Ensure that when audit results are sent to the business groups for actions these are consistently followed up. Issues with the completion of DNACPR forms had been highlighted in audits yet the completion of these continued to be variable in in quality.
- Ensure that the actions in the audit that identified a risk in terms of lapsed syringe driver training is followed up and ensure all syringe driver training is up to date.
- The service should consider formally auditing the rate of compliance with achieving patients' preferred place of care.
- The service should consider setting some clear target dates by when all EOLC patients should be supported by an IPOC and all staff required to have completed the EOLC training have done so.
- Ensure all risks affecting the provision of palliative and EOLC are identified on one service-led risk register. Some risks identified by the service, for example the level of EOLC consultant cover, were not included on the risk register. This meant that potential risks may not be managed as effectively as they would if they were regularly reviewed.

Outpatients and diagnostic Screening

- Ensure that number of overdue outpatient follow-up appointments, particularly in gastroenterology, are reduced.
- Ensure that floor areas in outpatients B can be cleaned in line with HBN00-09 guidance for Infection Control in the Built Environment.
- Ensure the staff groups requiring level three children's safeguarding training in the Safeguarding Children Training and Competency Strategy is reviewed.
- Ensure theprovision of sufficient car parking for patients at the Stepping Hill site is considered.
- Ensure patient feedback about changes made to outpatient services as a result of complaints is considered.
- Ensure participation in the Imaging Services Accreditation Scheme (ISAS).

Action the hospital SHOULD take to improve

- The hospital should ensure that all actions and lessons learned from serious incidents are regularly reviewed and completed appropriately.
- Consider monitoring all four harms outlined in the national safety thermometer for the emergency department.
- Consider reviewing the number of defibrillators within the emergency department to assess whether additional equipment is required.
- Consider that essential resuscitation equipment is regularly checked and that these checks are recorded in the emergency department.
- Consider that all appropriate risk assessments are completed for patients attending the emergency department.
- Consider that there are adequate numbers of suitably qualified nursing staff on duty at all times in the emergency department.
- Consider that all patients receive nutrition and hydration while in the emergency department.
- Consider that patients receive adequate pain relief within the emergency department if it is required.
- Consider that any actions which are recommended as a result of audits should be monitored and updated regularly.
- Consider that deceased patients and their families are treated with compassion and dignity at all times in the emergency department.
- Consider that medical patients are not accommodated on the CDU or MAU unless there are exceptional circumstances.
- Consider that patients waiting for inpatient beds in the emergency department are kept informed of any delays in their allocation of a bed.

Outstanding practice and areas for improvement

- Consider that there is clear nursing leadership within the emergency department and that the matron is able to undertake her management role effectively and unimpeded by the pressures of the department.

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
Nursing care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 10 (1)(2) (a) Service Users must be treated with dignity and respect. We observed multiple occasions where patients privacy and dignity was not maintained in the emergency department.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12 (1)(2) (a)(b)(c)(g)(h) Care and treatment must be provided in a safe way for service users. We found that risks to patients were not always recognised and assessed. Control measures were not always in place to mitigate these risks. Medicines were not always managed safely and were not always stored securely. Patients were not always protected from risk of infections. We observed patients who were not isolated when showing symptoms of a communicable infection and clinical areas were not always cleaned between patient uses in the emergency department.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Nursing care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 14 (1) The nutritional and hydration needs of service users must be met. We found that patients were not always provided with adequate nutrition and hydration in the emergency department. We fluid balance recording was not always completed.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17 (1)(2) (b)(c) Systems or processes must be established and operated effectively to ensure compliance. In the emergency department we found that key risks had not been identified and assessed including the risk of patients being placed and accommodated in non clinical areas such as corridors. Records were also not always up to date and lacked detail in some cases.

Regulated activity	Regulation
Nursing care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

This section is primarily information for the provider

Requirement notices

Regulation 18 (1)(2) (a)

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.

In the emergency department we found routine staffing deficits with 54 out of 121 shifts in a four month period being understaffed by at least one qualified nurse. The uptake for mandatory training for nursing staff and medical staff was significantly lower that the expected target in a number of subjects. The appraisal rates for staff were consistently and significantly below the trusts target.