Stockport NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Stockport NHS Foundation Trust provides acute hospital care and community-based health services for children and adults living across Stockport and the High Peak. Established as an NHS Foundation Trust in April 2004, the trust employs over 5,200 staff who work across a number of premises to deliver hospital and community-based services.

All acute hospital care is provided at the trust's main hospital, Stepping Hill, which is situated on the A6, just south of Stockport town centre. Surrounding Stepping Hill, and at the heart of the Stockport community, are a further 24 community-based health services and clinics.

In addition to its acute and community-based services, the trust also provides a number of bespoke specialist services which include; the Devonshire Centre for neuro-rehabilitation, the Meadows palliative care centre and Swanbourne Gardens, which provides overnight breaks for children and young people living with severe learning disabilities.

(Source: Acute Routine Provider Information Request (RPIR) – Context tab)

Is this organisation well-led?

Leadership

The trust board had a range of skills, knowledge and experience, however some of the services we inspected had deteriorated since our last inspection. The trust leadership team had knowledge of current priorities and most of the challenges and were taking action to address them. However, we found the executive team were not sighted on some significant concerns, particularly in the emergency department. There was recognition that the whole executive team were still a relatively newly formed team and further team development was planned. There was an ambition to be a clinically-led organisation and this was not yet realised.

Since the last inspection in 2018, there had been further changes to the trust board and there was now a fully substantive executive team, in place. There had been four executive appointments, including the appointment of a substantive chief executive and two non-executive director appointments since the last inspection. The chief executive had been in post for a year. Further changes were planned and the executive director portfolios were under review. The director of strategy role was being reviewed pending the retirement of the current postholder. The trust had agreed to appoint a new role of director of governance, risk and assurance to lead across the governance agenda, although at the time of inspection they had not started in the role. These arrangements seemed well considered and there was a focus on team building across the executive team.

The new chief executive had a sound understanding of the executive team and the leadership requirements for the organisation. Executive directors, particularly clinical leads, reported working more closely and collaboratively, with less silo working. However, there was recognition that the whole executive team were still a relatively newly formed team and further team development was planned.

There was a good range of skills, experience and tenure across the non-executive directors. The chair was an experienced non-executive director and had been with the trust for three years.

There were appropriate arrangements for induction and board appraisal along with a structured approach to skills assessment. The board recognised the need to undertake a formal board effectiveness review. At the time of the inspection, the trust was undertaking an overarching governance review with external support and planned to act on the recommendations of this review.

There was regular protected time for board development. The forward programme was under review to focus on the new trust strategy and associated delivery programme.

The trust directors recognised there was more work to do on talent management and developing the skill set of clinical leaders and middle management in order to deliver on the trust`s ambition to be a clinically led organisation. The trust was working with an external partner for quality improvement and was using a range of leadership development opportunities, although these arrangements needed to be embedded. There was an ambition to have a talent management strategy that was measured and fully represented the workforce at all levels. There was limited evidence of current succession planning.

There was a programme of board visits to services and a process to feed back and act on findings. The non-executive directors and governors were involved in the visits.

Board members were well sighted on the financial and operational challenges of the trust. However, during the inspection we identified significant concerns particularly regarding the care of patients with mental health needs attending the emergency department; these issues had not been identified by the leaders in the organisation. There were significant concerns with patient flow and this had not been effectively addressed.

Non-executive directors expressed frustration at the lack of traction on the delivery of recurrent cost improvement schemes and it was recognised this was an area for improvement. It was also recognised there was more work to do on tightening arrangements for the audit committee`s oversight of the overall system of internal control.

During the last inspection, we found that the trust could not always evidence they had effective mechanisms in place to ensure that board level leaders had the skills and knowledge in accordance with the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are

fit and proper to carry out this important role. At this inspection, we reviewed the recruitment process of the most recently appointed directors. We found improved compliance with the regulation; all recently recruited directors had the required checks recorded, however one had one reference rather than the two and no fit and proper person self-declaration in accordance with the trust's policy. The trust's fit and proper person policy was due for review.

We found progress had been made against key priories identified in the trust Medicine Optimisation Plan [2018-2020]. These included the development of specialist pharmacist roles and advanced roles for pharmacy technicians to support the medical and nursing workforce. The trusts medicines policy had been reviewed and updated however, procedures to support self-administration remained in draft. Similarly, ePMA [Electronic Prescribing and Medicines Administration] had been rolled out to the emergency department, but two electronic systems remained in use. As identified by the trust this increased the risk of medicines errors when patients were transferred to wards. Throughout 2019-20 there was a clear focus on improving antimicrobial stewardship, an identified area for improvement at the trust. A refreshed Medicines Optimisation Plan [2020-23] had been drafted, awaiting trust sign off.

Since our previous inspection the trust had made significant investment into the pharmacy establishment [from September 2019]. ePMA had been rolled out to Bluebell Ward and dedicated pharmacist cover put in place, improving oversight of prescribing and medicines optimisation. The Medicines Reconciliation audit had been extended to include paediatrics and surgery. Pharmacy support had been provided to the surgical pre-op assessment clinic and medicines reconciliation within surgery was showing an improving trajectory [Trust data Q3]

However, pharmacy staffing was in the lower quartile [NHS Pharmacy benchmarking 2019] and capacity within the team to cover for statutory absence was limited. This meant that senior staff were providing rota'd ward pharmacist cover, for example to escalation wards, putting pressure on delivery of other priorities. There was a risk that patients admitted via Ambulatory Care or Clinical Decisions, would have minimal or no pharmacy input in terms medicines reconciliation or monitoring prior to admission to a ward. ePMA was used to identify these patients, targeting those who have not had medicines reconciliation at 48hours.

Board Members

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 42.8% were female.

Of the non-executive board members 12.5% were BME and 37.5% were female.

Staff group	BME %	Female %
Executive directors	0%	42.8%
Non-executive directors	12.5%	37.5%
All board members	6.7%	40.0%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Vision and strategy

The trust had a clear vision and set of values with quality as a top priority. The trust had recently approved a trust-wide strategy; the development had intentionally taken a long period of time, since the last inspection, and was yet to be formally launched. Strategies to support the overall strategic direction, such as a clinical strategy, were being planned. There was a need to build the capability of the business groups to take forward key strategic initiatives. The strategic aim to strengthen health and social care partnerships in Stockport to achieve a more resilient urgent care patient pathway had commenced, but was at an early stage of delivery.

The vision of the trust was to have a health and care system that had excellent care at the heart of the community to achieve excellent patient care each and every time. The core values were quality and safety, communication, and service.

The trust has refreshed its five-year strategy through a large staff and partner engagement exercise with a focus on ensuring the vision and values resonated with these stakeholders. The strategy was high level and based on five strategic objectives and three values. It was linked to the needs of the health economy in Stockport and East Cheshire along with the acute service reconfigurations across Greater Manchester.

Whilst the trust had a good understanding of its service strengths and weaknesses, there was further work to do on the key enabling strategies. This was recognised by the board. The priority consideration was a clinical strategy, and this was in planning at the time of the inspection. This work was required along with supporting enabling strategies in respect of workforce, estates and finance to dovetail with the model of clinical sustainability.

The trust was cognisant of the need to build the capability of the business groups to take forward key strategic initiatives. Work to strengthen clinical leadership and engagement was sponsored by the medical director and there were plans to strengthen the focus on transformational capability in the business groups.

The linkage of the strategy with the trust`s operational planning arrangements was not evidenced albeit the trust was in the process of establishing its annual priorities for the forthcoming year in the light of the refreshed strategy. The trust faced several operational challenges matching patient demand to capacity and achieving key patient access targets. The board recognised that key to their ability to provide high quality, sustainable patient services was the need to deliver a more resilient urgent care patient pathway. The strategic aim to strengthen health and social care partnerships in Stockport to achieve this resilience had commenced but was at an early stage of delivery.

The board recognised an underlying deficit of over £30million. It was reported that an analysis of the key drivers of the deficit has been undertaken and had been subject to scrutiny through the finance and performance committee. This work was key to developing the roadmap to future financial sustainability.

There was a mixed picture on planning and delivery of cost improvements with a poor track record of delivering recurrent savings schemes. Historically the trust has delivered recurrent cost improvements of circa 2% per annum against an overall requirement of circa 5% per annum. Hence the trust has been reliant on non-recurrent efficiency measures to achieve its financial plan. A 5% per annum efficiency target was ambitious albeit the board were sighted on this requirement and considered there was a reasonable evidence base to support its attainment. Overall there remained a need to improve the robustness of cost improvement planning and its alignment with quality impact assessments.

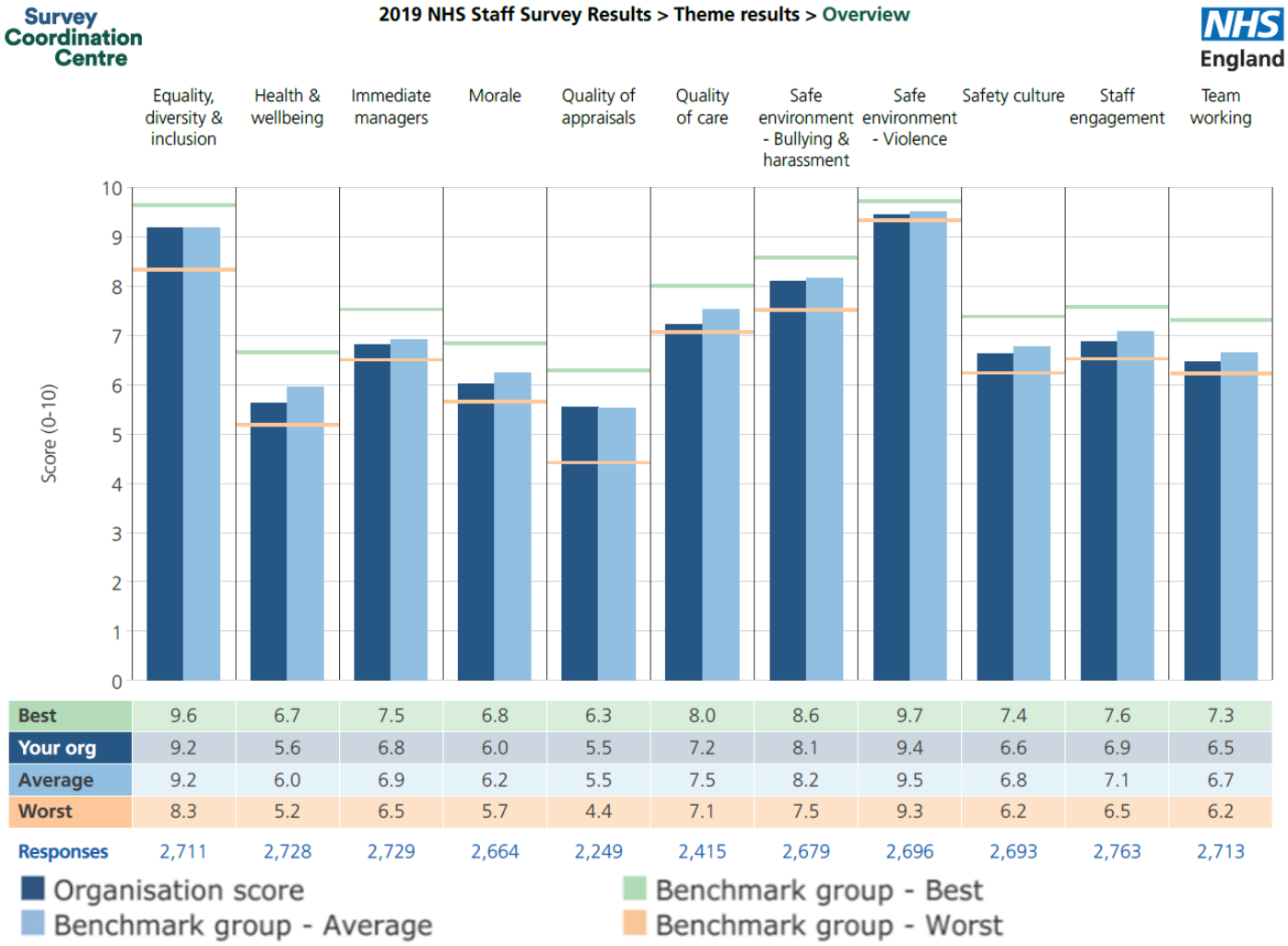
The annual medicines optimisation report to the quality committee provided an overview of medicines optimisation at the trust, highlighting progress made.

Culture

During our inspection we received mixed feedback in relation to the culture within the trust. Most staff described that the culture was positive, and they found it a ‘good place to work’ with a ‘supportive team approach’. However, staff in the emergency department, children and young people’s services and medicine had experienced a poor culture. The

main area of concern was the emergency department. However, improvements had been made to staff appraisals with an improved process and there had been a notable increase in the staff survey response rates.

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



There were no themes where the trust's scores were significantly higher (better) or lower (worse) when compared to the 2018 staff survey.

(Source: NHS Staff Survey 2019)

The 2019 staff survey results demonstrated that for the indicator for staff feeling supported and valued by their immediate manager, the trust performed just below the national average and was close to the benchmark group for the worst scores. During our core service inspection, we received mixed feedback from staff about feeling valued and supported by their line managers and the organisation. Junior medical staff, particularly those working within the medicine core service, described a lack of support from the senior clinical team at consultant level and highlighted out of hours and weekends as a particular concern. Staff in the emergency department told us that there was a 'lack of senior nursing support in the department at the weekend'.

Senior leaders had felt that the culture of the organisation was improving but recognised that this would take some time to change and embed. The senior leadership team had engaged with staff

across the trust to develop the trusts values and behaviours. We were told that there was further work to be done to improve the culture and we were told that there were plans to focus on engaging the senior clinical team to make positive changes to the specialities where there were issues with the culture.

The trust had a 'people strategy 2018 to 2023' with one of the objectives being 'culture and engagement'. As part of this the trust was focussed on health and wellbeing of staff, staff retention, promoting a learning culture and celebration of staff achievements. The trust was also working with NHS improvement and the North West Leadership Academy in respect of the cultural change programme. This programme would involve change champions being selected through an expression of interest and recruitment process. The first phase of the programme commenced in November 2019 and was planned to be completed in April 2020. It was planned that change champions would receive training from a regional leadership academy and be support throughout the project. The outputs were planned to be measured through a cultural dashboard and reported to the board.

Staff within the trust described a culture that was reactive in its approach to change rather than pro-active and as such made it difficult to make changes to improve the services. We were told that when changes were made, they were reactions to an issue and happened quickly with little consultation with staff and trade unions. The people strategy aimed to address this by coaching staff through change processes and upskilling staff in quality improvement methodology.

Staff and leaders described the workforce as hard working and committed to providing excellent patient care. Leaders were focussed on the needs and experience of people who used the services. This was particularly evident from the patient experience team who had implemented a number of initiatives to support patients accessing services and had worked with former patients to develop these. An example of this was the development of a 'veteran passport' as part of the armed forces support project which has resulted in the trust being 'veteran aware' accreditation. Patient stories were used during appropriate committee meetings to patients were invited to share their experiences in person, film or in narrative to support the trusts learning when things went wrong.

The trust had implemented the role of 'sepsis champion's as part of the sepsis action plan to promote ward level ownership and engagement with the wider multi-disciplinary team, to support improved recognition and treatment of patients with sepsis.

The wider pharmacy team was consulted and engaged in the development of the revised trust medicines optimisation plan 2020 to 2023. Senior pharmacists had lead roles in the delivery of key priorities.

However, whilst positive work has been undertaken during our core service inspection, we observed some patient care was below the standard expected. Staff described that due to high demand and issues with staffing and capacity particularly in the emergency department, they were not always able to provide the level of patient care they would want to.

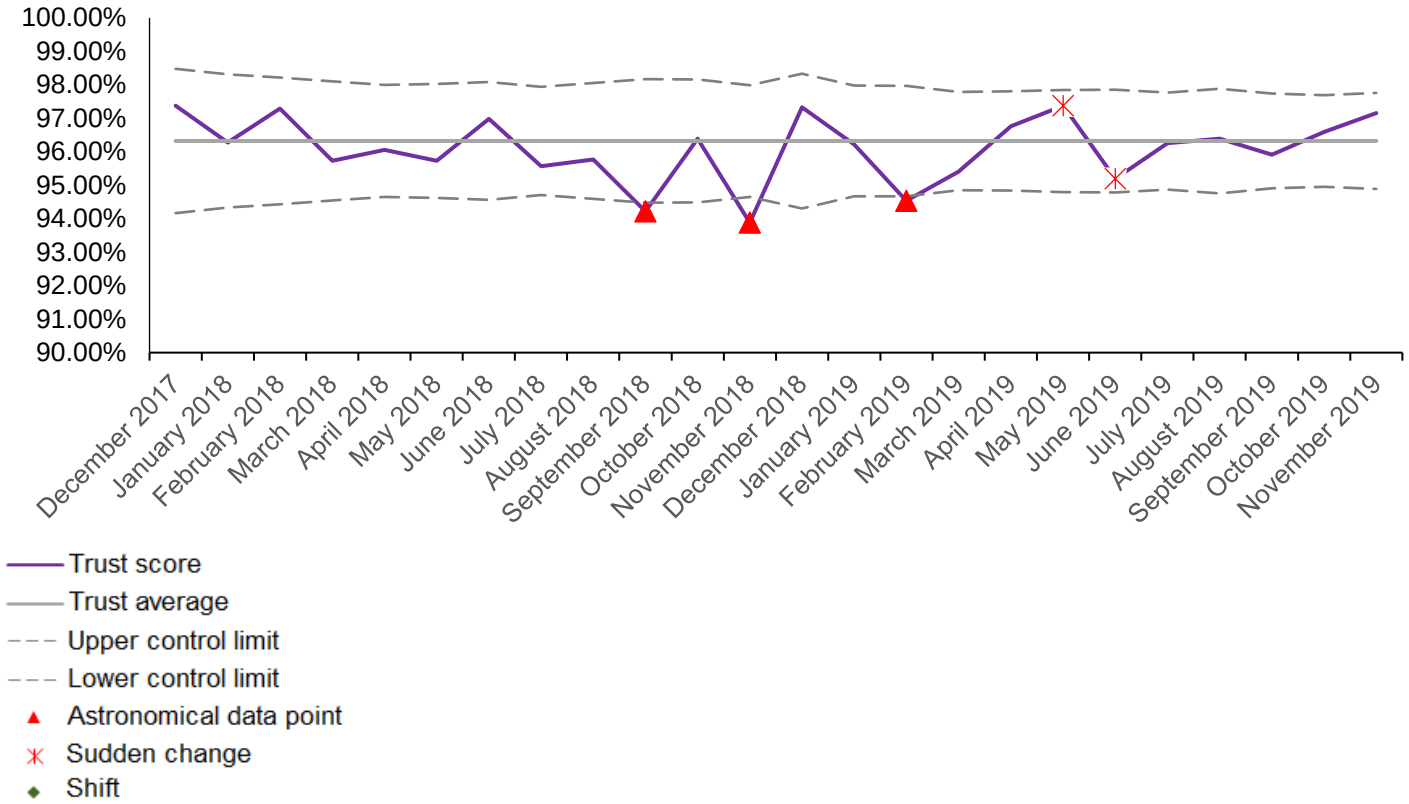
Between January 2019 and March 2019, the trust undertook a patient safety culture survey based on the Manchester Patient Safety Framework. The framework used ten dimensions of patient safety and for each of these, described what an organisation would look like at five levels of safety culture. 369 members of staff completed the questionnaire, which was approximately 7% of the staff employed. The data showed that on the whole, of the staff who answered the questionnaire, they believed that the organisation was proactive about safety issues and 60% of those who answered felt that the safety culture had improved over the last two years. There was 6% of those completing the survey who felt that the safety culture had become worse. The trust planned to undertake a further survey in 2020 to measure any changes.

Friends and Family test

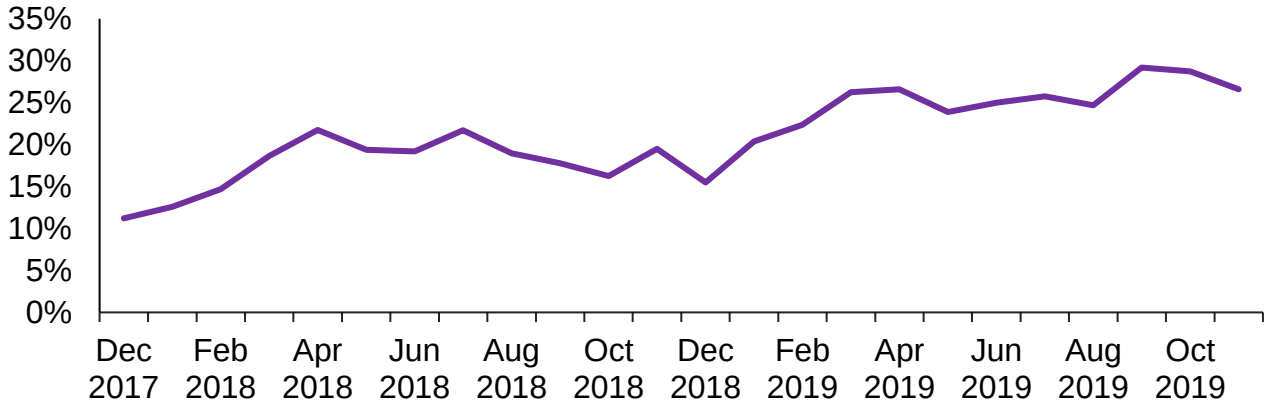
The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 93.9% and 97.4% from December 2018 to November 2019.

There were three points outside of the control limits and two high/low data points.

Friends and family test performance



Friends and family test response rate



(Source: Friends and Family Test)

The trust had a duty of candour and being open policy to ensure the requirements of duty of candour were met. Duty of candour is a legal duty that hospital trusts have to meet, to inform and apologise to patients if there have been mistakes in their care that have led to moderate or severe harm. The duty of candour aims to help patients receive accurate truthful information from health providers. Compliance with the regulation was monitored through the trust's incident reporting system and reviewed on a weekly basis through the governance situation report. There was an assigned trust lead for duty of candour compliance.

Duty of candour training was provided to all staff as part of their mandatory training. Senior staff who undertook root cause analysis investigations received additional training about how to deliver duty of candour and their responsibilities as lead investigators. There were identified senior staff for each business group who served duty of candour. During our core service inspection, we found that staff across all core services understood duty of candour, they were open and transparent and gave patients and families a full explanation if and when things went wrong.

All board members articulated the importance of finance and the commitment to deliver on the financial plan, however the overriding priority was patient quality and safety. Despite the challenging financial position, the trust has invested in additional clinical staff and enhancements of the hospital infrastructure to safeguard patient safety. Staff we spoke with were proud to work for the organisation and were committed to provide the best service they could.

Action was taken to address performance that was inconsistent with the vision and values regardless of seniority. There was a case log which recorded the types of issues reported against staff groups so that it could be monitored for themes and trends. The human resource dashboard gave an overview of specific areas of concern which could then be targeted with the appropriate support. The workforce and organisational development team had strong links with the General Medical Council to follow up concerns with regards to the performance and conduct of medical staff. There was engagement with the freedom to speak guardian to identify areas of concern so that they could be acted upon.

Leaders described a culture of openness and felt that staff were not afraid to raise concerns without the fear a retribution. However, during the core service inspection staff gave us a mixed picture of staff feeling able to raise concerns.

Between October 2018 and September 2019, the trust reported 40 whistleblowing incidents. The main themes were quality/ safety, bullying / harassment and unacceptable behaviour. These were reported through the freedom to speak up guardian for the trust. The concerns raised with an element of quality / safety followed the pattern of increase and decrease with the total number of concerns raised. We were told that concerns with a reported element of bullying / harassment or unacceptable behaviour had shown an increase over the last year. During the inspection, we were told by some staff that they had experienced a bullying culture. We were told that there was a ‘forceful downward’ approach to getting things done and staff felt this sometimes caused a risk to patient safety.

The trust leadership were taking action to address concerns about bullying. There had been a week in November 2019 which focussed on an antibullying campaign which included staff signing a pledge to stamp out bullying.

The trust’s freedom to speak up guardian was based in the trust headquarters for two days per week and they were not supported by freedom to speak up champions. However, there was a mechanism for feedback in place with the trust’s cultural ambassadors. During our inspection we were still concerned about the visibility and accessibility of the freedom to speak up guardian and we were not assured that recommendations from the National Guardian’s Office were adopted by the trust. This remained a concern from the 2018 inspection.

We received a number of whistleblowers during and after the inspection in the main relating to the emergency department. The concerns related to staffing shortages, patient care/safety and a lack of support for the department from the senior nursing and trust leadership team. When we spoke with staff during the core service inspection, we were told that in certain specialties staff did not always feel that they could speak up without consequences or that if they raised their concerns they would be acted upon.

The trust has made good progress on strengthening the resilience of its medical workforce but

there remained significant challenges with nursing workforce shortfalls which has had an adverse impact on staff morale.

There was a guardian of safe working who had been recently appointed. They provided the board with a quarterly report relating to concerns raised and medical rota gap incidents. We were told that there were currently no concerns with regards to rota gaps at the trust. However, when we spoke with junior doctor staff they had concerns about the setup of rotas particularly on call rotas. We were given examples of their concerns which included being rostered for rest days on teaching days which meant they missed out on vital training, being informed of their rota at short notice and some on call rotas where doctors were not given the full rest time.

There were monthly junior doctor forums and quarterly meetings which were attended by the executive team. We were told that these were not always well attended at that there needed to be a more visible presence of the guardian across the trust. We spoke with junior doctor teams who provided mixed awareness of the forums and those who were aware did not always feel that issues raised were acted upon.

General Medical Council – National Training Scheme Survey

In the 2019 General Medical Council Survey the trust performed the same as expected for all of the indicators.

(Source: General Medical Council National Training Scheme Survey)

The 2019 NHS staff survey results demonstrated that the trust was equal to the national average for the quality of appraisals. The appraisal completion rates for all staff from 5 October 2018 to 4 October 2019 was 77.9%; this was below the trust target of 95% compliance. During the core service inspection, we found that each core service had not met the trust target compliance rates with the urgent and emergency department having the lowest compliance rate.

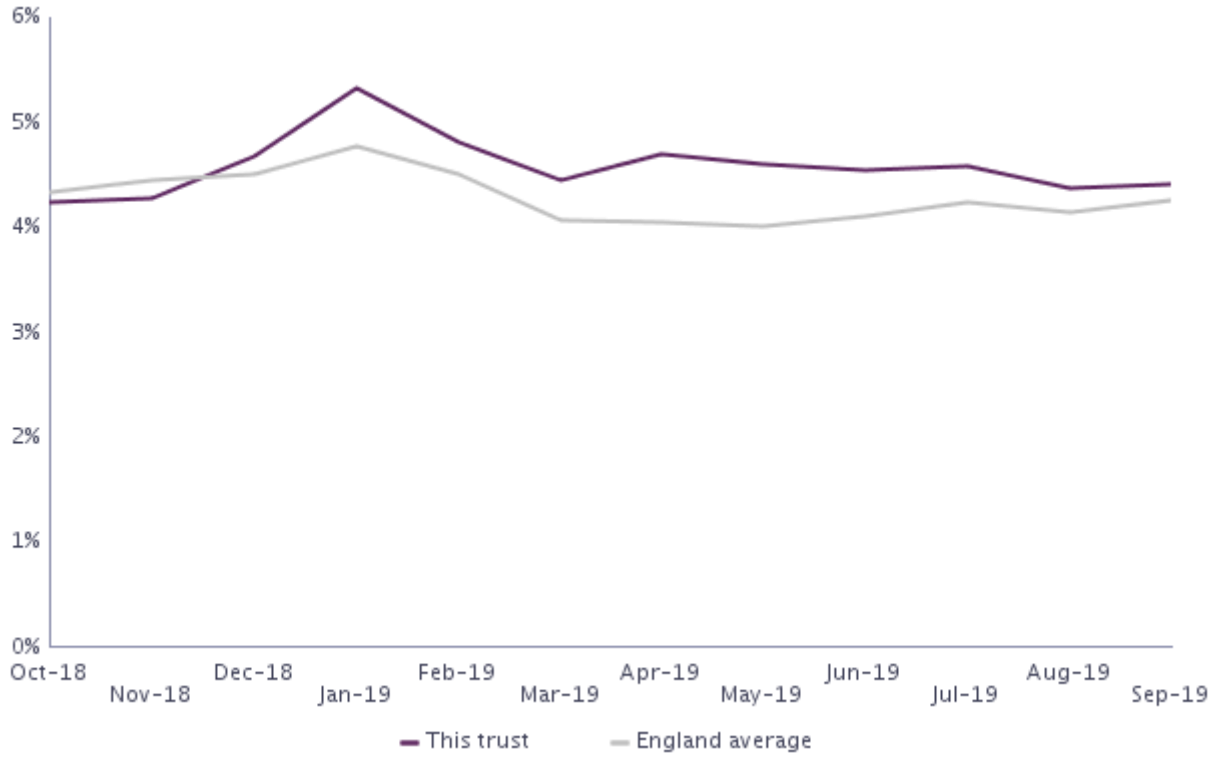
Were told that improvements had been made to the appraisal process and documentation as a result of feedback from staff in the staff survey. Staff spoke positively about the change and how it had more of a focus on their future development. The leadership team had felt that the most recent staff survey results had reflected the improvement since the change in process.

The trust had identified the need to develop leadership teams at all levels to make sure that leaders were creating a culture based around the values and behaviours that staff working for the trust had agreed to. Staff could access a number of leadership development courses which included quality improvement, coaching, human factors in healthcare and leadership and management apprenticeships at a variety of levels.

The organisational development team was in the process of creating a new leadership course which would be tailored to the needs of individuals rather than a standard course for all staff in leadership roles.

Sickness absence rates

The trust’s sickness absence levels from October 2018 to September 2019 were similar to the England average.



(Source: NHS Digital)

The trust's staff had access to support for their own physical and emotional health needs through occupational health. The trust's occupational health service was consultant led and was accredited as a safe effective quality occupational health service (SEQOHS). This meant the service provided was regularly assessed against a framework of best practice guidelines. In addition to support the health and wellbeing of staff there were a number of coaches across the organisation, staff had access to counselling services, mediation and a number of physical activity sessions. In 2018 the trust introduced Schwartz rounds which we were told had been successful and well attended with a wide representation from all staff groups. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another. The trust had an action plan following the last staff survey which had a focus on improving the health and wellbeing of staff.

Staff side representatives had worked closely with the workforce development team to improve the attendance management policy so that it provided more flexibility for those with long term conditions. The staff side team spoke highly of the engagement and support that they received from the director of workforce and organisational development team.

We were told that there had been an increase in staff sickness due to musculoskeletal and stress related illnesses. It was felt that this related to the pressure on ward staff with high volumes of patients and escalated beds. We were told that the wellbeing service for the trust had organised a number of events for staff to attend to support their wellbeing. However, we were told that due to service pressures staff were not always able to be released to attend these.

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white

and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	2.0%	4.9%	●	-0.2% →
1b. Proportion of non-clinical staff in senior roles, band 8+	3.4%	7.5%	●	-0.5% →
2. Proportions of shortlisted candidates being appointed to positions	62.6%	61.3%	●	51.1% ↑
3. Proportion of staff entering formal disciplinary processes	0.3%	0.4%	●	-1.1% ↑
4. Proportion of staff accessing non-mandatory training and CPD	96.5%	90.8%	Not assessed	

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there significant differences between...		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	21.4%	21.4%	22.8%	●	●	-2.0% →
	Peer group	*27.9%*	*25.3%*	*26.3%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	25.7%	22.7%	24.1%	●	●	-1.5% →
	Peer group	*29.3%*	*23.6%*	*25.1%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	77.8%	84.7%	83.7%	●	●	3.9% →
	Peer group	*69.5%*	*87.3%*	*84.2%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	8.7%	4.3%	5.3%	●	●	-6.8% →
	Peer group	*15.6%*	*5.9%*	*7.6%*			

Trust staffing numbers (*)	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[1]	●	[1]	●

Key

- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- → No statistically significant change
- ↓ Statistically significant deterioration

As of 2018, one of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

- 1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (2.0% of BME staff compared to 4.9% of White staff). This remained similar to the previous year, 2017.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), none of the indicators showed a statistically significant difference in score between White and BME staff.

There was one BME Voting Board Member at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2019; NHS England)

The people strategy set out five strategic aims, all of which had equality running through them. Race equality was most explicitly mentioned under aim two, which set out to create an inclusive culture and work environment. The work was being overseen by the equality, diversity and inclusion group, supported by a workforce race equality scheme steering group, and various staff networks (including a BME Network). Progress was planned to be measured through workforce race equality standards and equality and diversity 2 data and overseen by the people and performance committee. The strategy had been consulted on with staff through the staff networks and discussed with senior managers. At the time of our inspection the strategy was awaiting approval.

There was a trust's equality, diversity and inclusion manager. As part of the forward plan they would be focussing on two key areas of the data; these were supporting the workforce through the race equality standard with a focus on staff progression and to improve access and patient experience. In order to improve the workforce race equality standards results for staff progression, the trust was accessing places on a leadership course provided by NHS England however there were limited places available to staff. To offer more staff with protected characteristics the opportunity to attend leadership courses there was an in-house leadership course being developed. We were told in order to track improvement against the standard there was a plan to add it to the business group performance dashboards.

There were action plans for improvement of equality standard data which were regularly monitored and reported which included at board level. The trust chair was the board champion for equality, diversity and inclusion; ensuring senior leadership commitment to the agenda and strategic oversight and consideration of equality, diversity and inclusion and Workforce Race Equality Standard issues at board level. There were executive and non-executive directors who chaired the staff networks.

The trusts equality, diversity and inclusion (EDI) manager delivered bespoke training to staff across the organisation on various topics such as disability awareness, cultural competence and the Equality Act 2010.

The trust had a plan to achieve the accessible information standard which was identified to be completed in April 2020 and we were told that they were on track to achieve this.

Governance

During our 2018 inspection the trust had implemented a new quality governance framework and restructured the quality committee. This was to ensure that the trust provided an equal balance and assurance on all aspects of quality within the organisation so that it could measure and improve quality at all levels throughout all areas of the trust. During this inspection we identified that there were continued gaps in the governance processes and board assurance. However, the trust had commissioned an external governance review which was underway and there was a planned restructure of executive portfolios and a redevelopment of the governance approach for reporting risks.

Safety and quality assurance were monitored through a quality governance structure, reporting to the board via the quality committee. There were five groups that reported up into the quality committee. These were the safeguarding group, patient experience group, safeguarding subcommittee, medicines optimisation group and the quality governance group. Key issue reports were provided to the quality committee from its reporting groups. These were amalgamated and a quality committee key issues report was provided to the trust board of directors. We saw evidence of the reports and the decision-making process for agreeing the key issues report in the quality committee meeting minutes that we sampled.

Alongside the key issue reports, the trust had an integrated performance report which detailed indicators relating to quality and safety. This was broken down to business group level data. Business groups were invited to present their key achievements, risks and future plans to the quality committee on a rotational basis**.** We saw evidence that this happened monthly in the meeting minutes which we sampled.

Key performance indicators were aligned to the operational, financial, workforce and quality performance. This was the structure from business groups up to the board so that there was structure and continuity of information.

Arrangements for board committees were well established. There was an annual process for reviewing the work plan of these committees and reporting to the board. The board committees undertook considerable responsibility on the part of the board and the current governance review will report on whether there was an appropriate balance across their scrutiny versus assurance role and the board plan to act on this accordingly.

The trust's controlled drugs accountable officer ensured that the required controlled drugs quarterly reports were submitted to the local intelligence network. The trust was investigating one incident of missing controlled drug medication, and reviewed medication security in response to this. Regular monthly audits of safe and secure medicines handling continued to be completed by the trust.

There was a triumvirate management model within each of four business groups who reported to the chief operating officer. The four business groups reported into governance quality boards which fed up into the trust quality committee then up to the board. The trust had commissioned an independent review into their governance process to identify areas for improvement. Arising from the ongoing governance review there was a need to embed uniform governance arrangements across the business groups supported by appropriate training. A formal accountability framework setting out the responsibilities of the triumvirates and how they were held to account for performance was not in evidence during the inspection.

Through the core service inspection, we found governance processes were in place, but were not always effective. Information was fed up the committees to the board and back down to ward level. However, we found that there was a theme of a lack of oversight of key issues and therefore a gap in the assurance to the board. The main concerns we found were a lack of oversight of staff competencies, safeguarding training and risks to patients with mental health needs being treated in the emergency department and the paediatric wards not being identified and mitigated. It was confirmed on the inspection that the senior leadership team were not aware of these risks.

Weekly information relating to clinical governance including incidents, serious incidents, complaints, claims and inquests were reported to the trust management team, so that all the new governance activity was visible to senior leaders.

Medicines incidents were reported to both the Medicines Safe Practice Group and the Patient Safety Summit. In October 2019 the trust reported one medicines-related never event that involved the use of an incorrect insulin device. (Never Events are serious incidents that are

wholly preventable, NHS England). Appropriate action was taken by the trust to investigate the incident and to share learning both with the staff involved and more widely across the trust. The Governance and Quality Manager was supporting the trusts Medicines Safety Officer to develop their understanding of serious incident reporting and investigation.

Workforce race equality standards performance had executive or non executive sponsors for each network. There was a governance structure in place which meant information about equality diversity and inclusion was shared up from staff networks to the board. This went through the people performance committee. We were told that the lines of communication in relation to equality, diversity and inclusion were positive.

Arrangements for budget setting had been refreshed to provide a stronger focus on a realistic baseline rather than a prior year rollover. There was oversight from the finance and performance committee. The financial plan including the cost improvement plan for the forthcoming year was under development at the time of the inspection which was close to the beginning of the next financial year.

There was an established business case process. There were many tiers of scrutiny through the executive function and board committees which sometimes delayed the process.

There was generally good clarity on the coverage of executive director portfolios, however we were told that these were being reviewed. There was a plan to appoint a director of governance, risk and assurance.

Non-executive directors chaired committee meetings. They told us that they felt well appraised on the challenges. We were told that there was a good mixture of new and more experience non-executive directors. However, we were given mixed feedback about the level of challenge during committees and board meetings. We were told that there needed to be more challenge although there had been an improvement to this. However, there was further work to be done to ensure an adequate level of scrutiny and challenge. Through our review of the quality committee minutes we saw documented evidence of challenge from executive and no-executive directors. We observed a board meeting as part of the inspection we saw that there was some challenge from non-executive directors, but the responses often provided reassurance rather than assurance.

There was a memorandum of understanding in place with the local mental health NHS trust. There were weekly mental health liaison meetings with the local mental health NHS trust which included representatives from both trusts, the safeguarding team and police representatives. Whilst these processes were in place, we felt that there was further work required to strengthen the governance processes for treating vulnerable children and adults. This was reflected in the gaps identified in risk assessments for patients with mental health needs in the emergency department and the paediatric ward but also in the arrangements for patients with complex needs being treated on the wards. This remained a concern from the previous inspection.
During our inspection we identified that the policy for managing violence and aggression, and for alcohol withdrawal were overdue for review. Following a trust audit, the policy for managing violence and aggression was being drafted with support from the local mental health trust. Since our last inspection in 2018 a policy describing the covert (hidden) administration of medicines had been implemented.

Board Assurance Framework

The structure of the board assurance framework was coherent. It was being refreshed to align with the revised strategic objectives agreed by the board and, as with the trust`s overall risk registers, the calibration of risk to the delivery of strategic objectives was planned to be reviewed. The board assurance framework was reviewed by the board in tandem with the corporate risk

register with risks assigned to board committees for further scrutiny. The process appeared sound however there was the need to ensure risks were relevant and proportional.

The trust provided their Board Assurance Framework, which details seven strategic objectives within each and accompanying risks. A summary of these is below.

1. To achieve full implementation of the Trust's refreshed strategy
2. To deliver outstanding clinical quality and patient experience
3. To strive to achieve financial sustainability
4. To achieve the best outcomes for patients through full and effective participation in local strategic partnership programmes including Stockport Health Partnership / Stockport Neighbourhood Care / Integrated Service Solution
5. To secure full compliance with the requirements of the NHS Provider Licence through fit for purpose governance arrangements
6. To develop and maintain an engaged workforce with the right skills, motivation and leadership
7. To create an environment that maximises the use of resources to improve efficiency, patient experience and clinical quality

(Source: Trust Board Assurance Framework – October 2019)

Management of risk, issues and performance

Assurance systems were not always comprehensive. A review of governance, to include risk management, was being undertaken. Performance was monitored but was not always used to drive improvement. There were significant challenges to patient flow within the hospital. High numbers of medically optimised patients were awaiting discharge.

Although systems were in place to identify risks and issues, we found the leadership was not always fully sighted on risks. We were not assured there were effective governance systems to monitor quality, safety and risk, particularly across the emergency department. Without these patients were, or may be, at risk of harm through the lack of identification of, and subsequent review and mitigation of risks. We also had significant concerns that staffing gaps in the emergency department had not been escalated or actioned at speed. The trust acknowledged this and were taking action to address those areas identified during the inspection process. There was recognition that a system-wide approach was required to address and sustain the improvements needed. We will continue to monitor the trust and the actions taken to keep patients safe.

Prior to the inspection, the trust leadership had recognised the need to further develop their assurance systems. An external governance review was underway and the trust were in the process of appointing to a new post of director of governance, risk and assurance. A trust-wide risk committee, to provide oversight and ensure uniformity of approach, chaired by the chief executive was being introduced. The chief executive had identified the need to separate governance and assurance from service delivery and the actions being taken were to support this.

There were indications of an improved incident reporting culture at the trust. The trust held a weekly safety summit chaired by a clinical executive director. All moderate and high risk incidents were reviewed. Staff spoke positively about this process. The national reporting and learning system incident reporting rate per 1,000 bed days, April 2019 to September 2019 had significantly increased compared to April 2018 to September 2018. There had been an increase in low and no harm incidents and a decrease in moderate and severe harm.

Serious incidents were escalated and a 72 hour review completed in the form of a situation, background, assessment recommendation report. Themes from incidents were identified in the monthly governance report, and in the quarterly learning from experience reports. The trust identified that the themes from the last 12 months incidents were slips, trips and falls, development of pressure ulcers, medication errors, missed diagnoses and delays in follow up. The reports were discussed in the safety and risk group, the quality governance group and the quality committee. The reports were shared at the business group quality boards.

However, during the well-led part of the inspection, we reviewed nine serious incident investigation reports. We found in four out of the nine cases, there was a narrow view taken as part of the investigation, for example a lack of consideration of safeguarding and wider implications. Investigation reports did not always clearly identify contributory factors and root causes. This meant there was a potential for missed opportunities for learning.

Whilst there was a process in place for sharing learning from incidents during our core service inspection, we were given a mixed picture about how learning from incidents was shared with staff. Staff told us that they were not always aware of the wider learning from incidents particularly for those that they had not been involved in or that had happened in a different department in the trust. From our review of serious incidents we found that there were missed opportunities for learning from some incidents and that the investigations did not always consider the wider context to why an incident occurred which could have provided some learning.

There were significant challenges to patient flow within the hospital. High numbers of medically optimised patients were awaiting transfer or discharge. On 29 January 2020, 111 patients were medically optimised. A medical director was leading a multiagency team on a programme of work to reduce days away from home for patients; this was starting to see some results, but had not yet had a significant impact.

Monthly performance reviews were in place with each of the business groups with the executive team but needed further developing. The reviews of performance captured a description of the current position but were not yet focused on actions and informing the next steps to address the areas of performance identified. There was a recognition at a senior level that the trust needed to be clear on priorities and accountable against agreed delivery metrics and deadlines. Given the significant operational and financial challenges faced by the trust it was recognised there needed to be a more uniform approach including clarity on the accountability framework. These improvements were work in progress as part of the governance review.

There was also a recognition that there was a lot of information provided to the board, but this was not always providing assurance.

The trust was performing well below target with respect to the number of patients who received intravenous antibiotics within one hour, as a percentage of all eligible patients found to have sepsis. A trust programme to support ‘Improved recognition and treatment of patients with sepsis’ was in progress, as part of the Moving to Good (M2G) initiative, supported by NHS improvement. Delivery against the sepsis action plan was managed by the sepsis steering group, with oversight from the Quality Committee. Antibiotic and sepsis data was reviewed at ward level to identify those wards that were performing well and to identify those where improvement was needed.

The trust did not achieve 2018/19 CQUIN [Commissioning for Quality and Innovation (CQUIN)] targets for total antibiotics and carbapenems consumption or for antibiotic prescribing review. Due to staffing capacity the trust had not been able to maintain comprehensive antimicrobial stewardship rounds throughout 2019. These were re-instated in September 2019, supported by a new multidisciplinary team approach, as part of a quality improvement project to improve antibiotic

stewardship across the trust. Additionally, a new antibiotic stewardship dashboard was implemented [2019/20 Q4] to provide business group and ward level information.

Then trust was reporting good compliance against the 2019/20 CQUIN [95% YTD Q2] for 'Antibiotic prophylaxis for elective colorectal surgery', but poor results for 'Lower urinary tract infection (UTI) prescribing in older people' [33% YTD Q2]. There was a focus on staff education to reduce unnecessary urine dipstick testing that could lead to inappropriate antibiotic prescribing and missed diagnosis.

Finances Overview

The trust had accepted its control total for the current year although there were risks to delivery due to gaps in the cost improvement programme and premium workforce costs. The board were sighted on these risks and had reasonable confidence these could be mitigated.

At the time of the inspection the financial plan for the forthcoming financial year was under development and predicated on a large cost improvement requirement of circa 5% which had a significant risk of delivery.

Financial metrics	Historical data		Projections	
	Previous Financial Year (2017/18)	Last Financial Year (2018/19)	This Financial Year (2019/20)	Next Financial Year (2020/21)
Income	£285m	£295m	£325m	£325m
Surplus (deficit)	-£22m	-£31m	-£4m	-£4m
Full Costs	£307m	£326m	£329m	£329m
Budget (or budget deficit)	-£27m	-£34m	-£4m	-£4m

The deficit reported in 2018/19 was higher than the previous year. Projections for 2019/20 indicated that the deficit will decrease.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Trust corporate risk register

There was an understanding of the process for reporting and escalating risk within the trust. However, the corporate and operational risk registers were cumbersome and there was a large number of significant risks which made risk profiling and prioritising difficult. The trust had plans to undertake a review of the risk management system which needed to include a review of the arrangements for scoring risk. Risk appetite had recently been discussed at the board.

We found some areas where risks had been clearly identified and these were being managed. For example, the trust had recognised a number of previously unidentified risks regarding estates, equipment and facilities. The risks were clearly identified, and action plans and governance arrangements had been put in place to manage the risk, although it was acknowledged this required investment to be sustainable.

The trust provided a document detailing their highest profile risks. Each of these have a current risk score of 15 or higher.

ID	Description	Risk	Risk	Next

		score (current)	level (target)	review date
130	There is a risk that the ED 4 Hour Standard will not meet its required monthly trajectory	20	10	16/12/2019
505	The risk of the lack of capacity in Cellular Pathology on turnaround times and patient pathways	20	4	31/10/2019
586	There is a risk of deterioration of the hospital site due to a significant increase in Estate Backlog Maintenance	20	8	31/03/2020
978	There is a risk that the Trust will not deliver its 2019/20 financial performance	20	5	31/10/2019
1004	There is a risk of significant breaches of the Regulatory Reform (Fire Safety) Order 2005	20	8	31/12/2019
1030	There is a risk the BG will not meet the CSEP target of £2.4m	16	12	31/10/2019
1046	There is a risk the Trust is non-compliant with statutory H&S legislation due to non-appointment to statutory positions	16	8	31/03/2020
1069	There is a risk of POCT management failure due to the pressure on the staff and limitations of resources	16	8	28/11/2019
1112	There is a risk to the organisation due to noncompliance with BSQ Regulations due to Loss of Traceability of blood components	16	4	29/11/2019
1138	There is a risk that patient care is compromised due to significant nurse staffing shortages within the ED	16	8	06/01/2020
989	There is a risk of delaying treatment especially cancer patients with the removal of fax machines	16	4	27/12/2019
125	There is a risk that patients care could be compromised due to insufficient Emergency Department Medical Staffing	16	8	06/01/2020
429	Inadequate capacity to meet demand in Paediatric ADHD Services	16	8	31/10/2019
686	There is a risk that patient care may be compromised due to significant staffing shortages within AMU	16	8	16/12/2019
765	There is a risk to the delivery of the CT service and patient safety due to a delay in installing 3rd CT scanner	16	4	24/12/2019
872	There is a risk to patient experience and safety due to Endoscopy Capacity and Demand	16	1	29/11/2019
183	Failure to meet the 62-day Cancer target standards	16	8	31/10/2019
50	Risk to maternity service continuity and safety due to midwifery staffing levels	16	8	30/11/2019
67	There is a risk to service delivery due to the lack of Consultant Microbiologist Cover	16	8	31/12/2019
78	There is a risk to patient safety due to the registered nursing staffing deficit within Medicine & CS	16	8	
86	There is a risk of the Trust's Telephony System failing due to aged telephone technology/infrastructure	15	15	31/01/2020
400	There is a risk to 18-week targets and compliance with NICE guidance.	15	9	31/03/2020

407	There is a risk to patient safety due to the number and length of the Respiratory Overdue Waiting List (non confirmed cancer)	15	6	20/12/2019
916	There is a risk that due to gaps in Orthodontic medics we are unable to meet demand for the service	15	3	28/10/2019
957	There is a risk to patient care if the Laboratory Information Management System (Telepath) Fails	15	10	31/12/2019
587	There is a risk to the operation of the Trust electronic syst/ntwrk due to the need to recruit Senior IT Technical Support	15	10	30/09/2019
996	This is a risk of the Trust not achieving a 7-day target for Clinical Correspondence	15	6	30/11/2019

(Source: Trust Corporate Risk Register)

Information management

Information was available for leaders to enable them to have an understanding of performance. However, there were limits on the ability to interrogate the data and a recognition that information was used to provide assurance and reassurance, rather than to measure for improvement.

A digital strategy was being developed and a clinical engagement strategy would be needed to support this. The importance of clinical engagement in the development of digital systems was recognised. Evidence suggested engagement was mixed, although the digital team did include nursing staff and allied health professionals.

The trust had developed in-house systems and consequently had some flexibility to update or amend systems. There was more digital maturity in the community settings with a move to paper light and mobile systems.

There was a large integrated performance report provided to the board which was comprehensive in its coverage of key metrics for quality, safety, workforce, finance and operational performance. The volume of information meant it was a challenge to identify priority issues for the board to enable clear focus.

There were positive comments about the commitment of the trust`s information management team and the large range of performance dashboards they produce. However, the trust was limited by the lack of a data warehouse and the opportunity to build analytical capability in the business groups. Plans to address this requirement were being developed.

The trust had ended the implementation of an integrated electronic patient record system due to significant deficiencies with functionality. It was however achieving good connectivity across standalone electronic systems and planning to build on their success in this regard. This was a pragmatic approach given the other challenges faced by the trust.

There were no reported issues with data quality and there was a rolling programme of data quality reviews with oversight from the finance and performance committee in the main.

The board received a finance dashboard covering all key metrics. A more granular finance report was presented to the finance and performance committee and provided coverage of income and expenditure, balance sheet, cash flow, capital expenditure and variance analysis, including business group performance. Risks to forecast outturn were identified although were not well

quantified. Given the magnitude of the trust`s financial challenge the report would benefit from sensitivity analysis to set parameters on best and worst-case scenarios for forecast outturn to manage expectation on the level of risk. Progress on the cost improvement programme was subject to separate reporting.

Whilst the trust was an exemplar site for the standard of its service level reporting it was acknowledged there was more work to do in using this analysis to inform clinical service decision making and in cost improvement planning.

The trust had completed the data security and protection toolkit. The standards for 2018/19 at 31 March 2019 had been met. This assessment provides a mechanism for organisations to demonstrate that they can be trusted to maintain the confidentiality and security of personal information.

Engagement

Engagement with external partners to enable system-wide improvements for patients had not always been effective. Action was being taken to promote more cross-sector partnership working. Steps had been taken to improve clinical and staff engagement, however there were opportunities to strengthen this further. There were positive examples of people who used the services and the public being engaged and involved in improvements.

There was a recognised need and willingness by trust leaders to work with key partners including the local authority and the NHS organisation that provided mental health services to the people of Stockport. At the last inspection, we found the trust was part of the 'Stockport Together' partnership to integrate local health and social care. However, the Stockport Together programme had not progressed as originally anticipated. There was real recognition at the trust of the need to engage with external key partners and the executive team, in particular, the chief executive had been proactive with key external engagement since commencing in the role. Indeed, during our inspection, processes were set up to support the trust and external partners to work across the system to drive the improvement needed.

The chief executive met with system leaders across Stockport and Greater Manchester and was the lead for the Manchester Reform Board jointly with the clinical commissioning group.

The trust had recently appointed a director of communications and corporate affairs who was responsible for the development of an overarching communications and engagement strategy (including public engagement) to support delivery of the trust's revised strategy.

The trust was part of the National Acute Frailty Network project, leading collaborative work across the Stockport area to develop pathways to ensure people identified as clinically frail receive the right support, at the right time and in the right place. As part of the 'in hospital' work the trust had established a frailty team within urgent care.

The trust was engaged with Greater Manchester Health and Social Care Partnership as part of roll out of Transfers of Care Around Medicine (TCAM) to trusts across the integrated care system. This project will identify patients taking high risk medicines or with frailty that would benefit from Community Pharmacy support with their medicines on discharge from hospital.

Steps had been taken to improve clinical and staff engagement, however there were opportunities to strengthen this further. Communication systems such as the intranet and newsletters were in

place and we saw examples such as the seven-minute briefings for staff on subjects such as dementia.

The trust reported that over 1,000 members of staff had been involved in the development of the trust's new strategy. However, whilst most staff were positive about increased engagement, we also found examples of missed opportunities to engage fully with internal stakeholders, such as staff side. There were also areas of the trust, such as the emergency department, where despite efforts to improve engagement, staff reported they did not always feel listened to.

Governors that we spoke with felt engaged with the trust and the leadership team. They had been engaged in the strategy development. However, some felt that changes to the meeting structures had limited their ability to engage directly.

The trust had a patient, carers, family and friends experience strategy for 2018 to 2021. This detailed key work streams and outcome measures. The implementation of the strategy was supported by quality matrons. There was a recognition that engagement was integral to the patient experience. We found several positive examples of patient engagement, including patient representatives on the patient experience group and involved in the dementia strategy and nutrition group, volunteers conducting a programme of real-time patient surveys, and the development of a veteran's passport as a result of feedback from a patient.

We found positive examples of where public engagement had been used to inform developments, such as work with the deaf community to inform the new interpreters contract. There were links with community groups such as the girl guides, local colleges and the Women's Institute. A patient story was heard at each trust board meeting.

The pharmacy team also supported patients using the rheumatology service both directly through answering patient queries and through ensuring shared care agreements were in place to enable treatment and monitoring to be accessed through primary care where this was in the patient's best interests.

Learning, continuous improvement and innovation

In the main we found that leaders and staff strived for continuous improvement and innovation. The trust was utilising external training for staff in nationally recognised quality improvement methodologies and staff were working together to make changes and improve services. There was evidence that they were engaged in research projects and were undertaking reviews internally and externally in order to improve services. However, we found that due to high demand, staff were not always able to take time out to work on improvement projects.

The trust recognised that there were areas which they needed to improve on and had commissioned a number of internal reviews recognising the need to make improvements to systems and processes. There had been quality assurance visits to the colonoscopy department, a commissioned external review into the trust's governance processes and at the time of our inspection the trusts was working with an external company to improve patient flow through the hospital journey. As a result of the reviews there had been approved business cases for building work, changes were being made to the governance structure, executive portfolios and senior director posts created to strengthen the leadership team.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an

accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	5 yearly JAG visit completed in March 2016, with annual assessments passed year on year. The next JAG visit is due March 2021.
Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care	The specialist palliative care team have previously registered for the National End of Life Care Programme for Hospitals which included: • Advance Care Planning (ACP) • Electronic Palliative Care Coordination Systems (EPaCCS) • AMBER care bundle • Rapid Discharge Home • Individualised Care of the Dying Progress has been made progress in all of these areas. Advance care planning is one of the Trust Quality Objectives for 19/20, the Rapid Discharge Pathway has been reviewed and the individual plan of care in hospital and community has been revised and launched successfully with good evidence of a positive change in practice. Our current aim is to incorporate the principles of identification/ co-ordination and management of uncertainty rather than embed the programme specifically and this will be reviewed as part of the EOL strategy update in the next few months once the Greater Manchester Palliative and End of Life Care Framework has been launched.
Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189	All areas in the labs have been CPA accredited for over 20 years. Biochemistry, Haematology and Transfusion and Microbiology (including Andrology) achieved UKAS accreditation to ISO 15189 in September 2018 Accreditation of haematology has been temporarily suspended following assessment in March 2019. The area is extremely short-staffed. Risk assessments and action plans are in place

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

The finance team were engaged in staff development activities. The team had been awarded level three accreditation under the Future Focused Finance Staff development programme and had also received a regional finance award for the "Best Place to Work".

There was a ward accreditation scheme in place which was the accreditation for excellence programme (ACE). The ACE system inspected wards against 20 care and safety standards, values were placed on achievement of the standards and a rating of gold, silver, bronze and white was given to wards based on the standards they achieved, with identified recommendations for improvement against the standards where necessary. We were told that

the accreditation scheme had began being rolled out to the community services. Six wards were rated Gold, 13 silver, one bronze and three white. In addition to the ACE inspection and accreditation the board of directors and clinical teams undertook quality visits through patient safety walk arounds in the hospital and community settings.

The trust had a research department which was supported by funding from the National Institute of Health Research (NIHR) who provided the infrastructure for research delivery in the NHS. There was regional support through the NIHR and the trust was part of the Greater Manchester Clinical Research Network. There were more than 70 clinical staff members delivering research studies at the trust and there were other who were contributing to research studies focused on improved health services and delivery which included on-line survey completion to improve knowledge in key clinical areas.

In 2018/2019 there was access to research recruitment across 18 out of a total of 30 NIHR specialties. The trust identified this was higher than other district general hospitals in the Greater Manchester area. In 2018/2019 the trust actively recruited into 50 out of 86 open research studies this was an increase from the previous year 2017/2018 where 47 studies were recruited to from the 76. The research studies were a mixture of commercial, academic and NHS trust trials. In the main staff were aware of research trials which their department contributed towards.

The trust has introduced a quality improvement faculty programme to provide a framework to underpin and develop their approach to continuous improvement. There were four strands of focus for this which were leadership, capabilities, systems and communications in order to embed a culture of continuous improvement within the trust.

At the time of our inspection the QI faculty was still in the development stages and there was work ongoing to embed methodology, training and a culture. The trust had adopted a quality improvement methodology and was being supported by Advancing Quality Alliance (AQuA) in the rollout of this methodology. There were some positive examples of high-quality clinical services including stroke, orthopaedics and urology which have been externally recognised.

Senior clinical staff were positive about the quality improvement approach and focus. We were told that a number of clinical leaders had received nationally recognised quality improvement training through AQuA and were supporting staff in their specialities to progress projects.

Teams took time out to work together to review processes, performance and resolve problems. We saw evidence of a number of projects which were ongoing across the trust to make improvements to patients care and outcomes. We saw that the projects utilised quality improvement methodologies using various tools to plan and evaluate outcomes. There had been improved work to develop more streamlined pathways for prostate cancer diagnosis which had led to the total time to biopsy reducing from 42 days to 28. The positive results have mean that additional funding has been provided to the trust to adopt the ‘straight to test’ model for colorectal patients to streamline that pathway and there were further plans to adopt a similar approach for suspected lung cancer.

The trust had made improvements to elements of its safety performance over the last 12 months. In 2018/2019 the trust reported a 50% reduction in patients sustaining pressure ulcers in the community setting, there had been a 20% reduction in falls and a 29% reduction in falls causing harm of moderate or above severity.

There was a weekly patient safety summit which looked at the top incidents for the week which had been assessed as causing moderate harm or above, low harm, near misses and those relating to staffing, infection control, security and safeguarding. Clinical teams were challenged to draw out learning to support these incidents which were shared trustwide via an email bulletin. Staff felt that this was a positive process and demonstrated to all staff that incidents were taken seriously, and learning was identified and shared. Senior staff felt that this had resulted in an

increase in incident reporting across the trust.

The trust followed a structured judgement review process for learning from deaths. We sampled five structured judgement reviews for patient deaths, we observed appropriate escalation to the medical director for the trust and we observed that learning had been identified for each review. We reviewed six incident reports for patient deaths and saw evidence that these had been appropriately escalated to a structured judgement review and mortality and morbidity meetings where appropriate.

There had also been focussed work on improving the trusts hospital standardised mortality rates. There had been positive results following this work and the trust had seen a decline in mortality since July 2019.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	**In days**	**Current performance**
What is your internal target for responding to complaints?	3	100%
What is your target for completing a complaint	45 working days	74%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	N/A
	Total	**Date range**
Number of complaints resolved without formal process in the last 12 months?	1,100	October 2018 to September 2019

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

From October 2018 to September 2019, the trust received a total of 412 complaints. The highest number of complaints were for Medical care, with 21.8% of total complaints, followed by Surgery (18.7% of complaints) and Outpatients (16.7%).

Core Service	**Number of complaints**	**Percentage of total**
AC - Medical care (including older people's care)	90	21.8%
AC - Surgery	77	18.7%
AC - Outpatients	69	16.7%
AC - Urgent and emergency services	49	11.9%
AC - Gynaecology	24	5.8%
AC - Services for children and young people	22	5.3%
AC - Maternity	21	5.1%
Provider wide	16	3.9%
AC - End of life care	14	3.4%
CHS - Children, Young People and Families	10	2.4%
AC - Diagnostics	8	1.9%
CHS - Adults Community	7	1.7%
Other	3	0.7%

CHS - End of Life Care	1	0.2%
AC - Critical care	1	0.2%

The three main subjects of complaints were clinical treatment, communications and patient care. These three subjects accounted for 62.5% of all complaints.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From October 2018 to September 2019, the trust received a total of 1,388 compliments. The highest number of compliments were for Medical care, with 34.7% of total compliments, followed by Community Adults (25.6% of compliments) followed by Urgent and emergency care (8.1%).

A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
AC - Medical care (including older people's care)	481	34.7%
CHS - Adults Community	355	25.6%
AC - Urgent and emergency services	112	8.1%
AC - Surgery	107	7.7%
AC - Maternity	88	6.3%
Other	78	5.6%
AC - Outpatients	60	4.3%
AC - End of life care	44	3.2%
AC - Critical care	26	1.9%
Provider wide	13	0.9%
AC - Gynaecology	8	0.6%
AC - Services for children and young people	8	0.6%
CHS - Children, Young People and Families	4	0.3%
AC - Diagnostics	4	0.3%

Over the last 12 months, the key themes the trust identified from compliments received, highlighted that staff were very caring, compassionate, willing to go the extra mile and hard working.

(Source: Routine Provider Information Request (RPIR) – Compliments)

There was a delegated Executive Director for the trust responsible for the management of complaints. There was designated line management and performance review of the complaints process. The central complaints team had a process in place for the leadership and monitoring of complaint handling. There was a designated complaints handler for each of the four business groups who were responsible for co-ordinating the investigation process and the preparation of the response. We saw evidence that patients had been involved in the complaints process and that changes to practice and learning had taken place as a result of complaints received. During our core service inspection, it was evident that all staff were aware of learning that had been shared following complaints.

Acute services

Urgent and emergency care

Facts and data about this service

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

Patients are assessed and streamed to the most appropriate service for their needs (resus, majors, psychiatry, minor injury, primary care or direct to a specialty in the case of healthcare professional referrals) in either an adult or paediatric setting within the same footprint. Patients considered frail have additional assessments within the urgent care environment and, if admission is required, can be cared for on a dedicated Short Stay for Older People (SSOP) unit.

Patients presenting to the emergency department between the hours of 9am and 11pm with a stroke are immediately transferred to the co-located hyper acute stroke unit (HASU).

(Note: The SSOP unit and the HASO unit are reported within our medical care report).

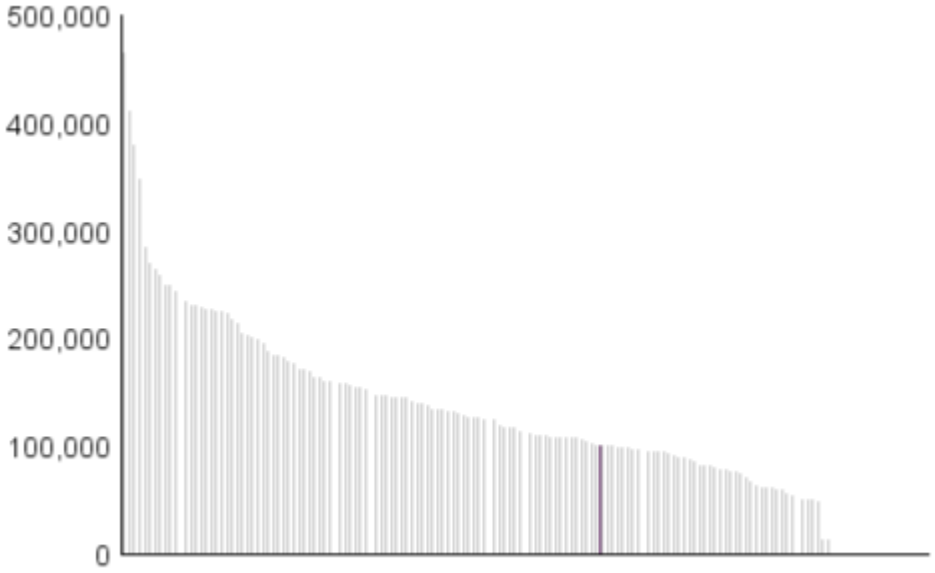
Stepping Hill hospital is one of three designated trauma units in Greater Manchester (GM) working within a wider network to ensure the best care for major trauma patients for whom safe transfer to immediate treatment is paramount.

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

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Activity and patient throughput

Total number of urgent and emergency care attendances at Stockport NHS Foundation Trust compared to all acute trusts in England, July 2018 to June 2019



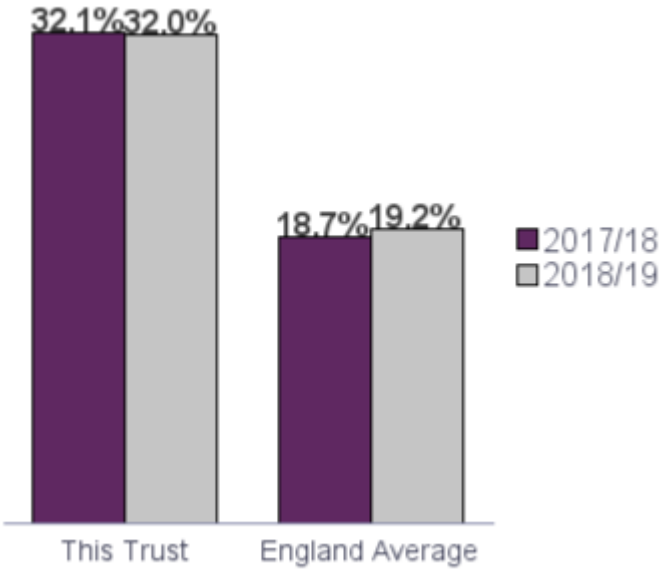
From July 2018 to June 2019 there were 100,429 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

Between January 2019 and December 2019, there were 100,520 type one attendances at the department. Type one emergency departments provide full major emergency services and have resuscitation facilities. Of these, 55,753 patients were treated in the department's 'majors' unit, 24,866 were treated in the department's 'minors' (minor illness/injury) unit, and 19,858 children were treated in the paediatric emergency department. The remaining 61 patients were treated in the department's resuscitation area.

Between January 2019 and March 2019, there were a further 1,808 type three attendances at the service. Type three departments are for walk-in attendances for minor illness or injury.

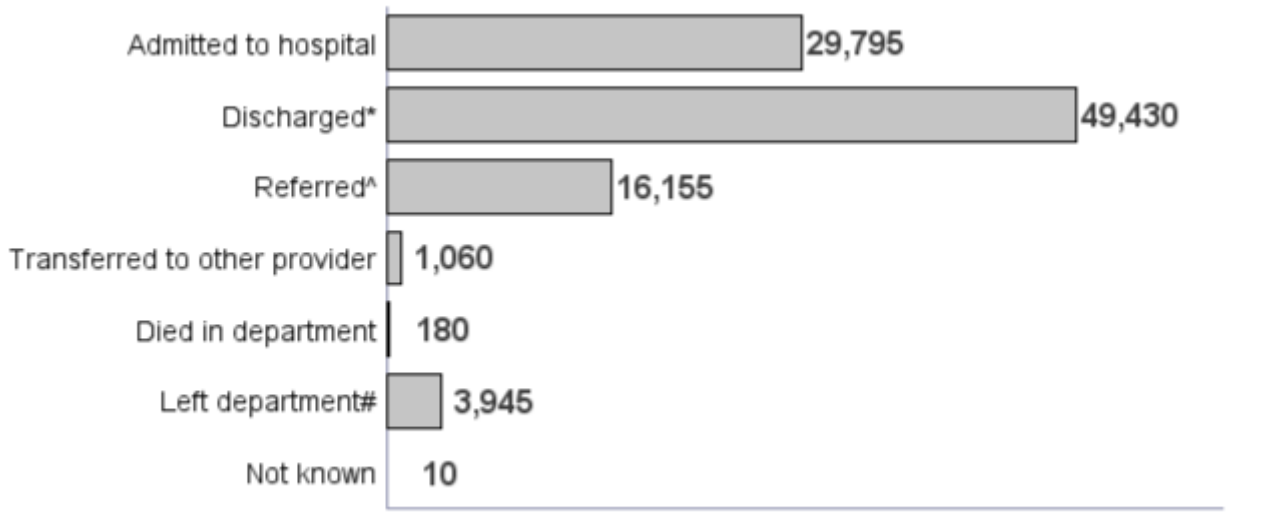
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2018/19 compared to 2017/18. In both years the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from September 2018 to August 2019



*

Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service did not ensure nursing and medical staff completed the mandatory training in key skills. However, there were good levels of compliance by medical staff with the highest forms of life support training.

The mandatory training programme was comprehensive and met the needs of patients. However, although managers monitored mandatory training, nursing staff did not always keep up-to-date with their mandatory training.

The service told us five band six and band seven (25%) nursing staff had received advanced life support training; a further eight staff were booked for this training in April 2020 and it was expected that a further eight places would be available in October 2020. A further 43 staff had received immediate life support training, and seven staff had received paediatric basic life support training.

(Source: Post inspection data request DR2c)

Medical staff did not always keep up-to-date with their mandatory training. However, there were high compliance rates for life support training. Of the ten consultants, all were up-to-date with advanced life support training (ALS), eight were up-to-date with advanced trauma life support training, and nine were up-to-date with advance paediatric life support training.

Of the six speciality and associate specialist (SAS) and senior clinical fellowship (SCF) doctors, five were up-to-date with advanced life support training, four with advanced trauma life support training and three with advanced paediatric life support training.

Of the seven speciality trainees (ST3+), all were up-to-date with advanced life support training, five with advanced trauma life support training, and seven with advanced paediatric life support training.

Mandatory training completion rates

Trust level

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Manual Handling - Object	96	101	95.0%	90%	Yes
Infection Prevention (Level 1)	96	101	95.0%	90%	Yes
Fire Safety 3 years	87	101	86.1%	90%	No
Medicine management training	78	95	82.1%	90%	No
Health and Safety (Slips, Trips and Falls)	82	101	81.2%	90%	No
Information Governance	89	113	78.8%	90%	No

Basic Life Support	62	79	78.5%	90%	No
Infection Prevention (Level 2)	67	87	77.0%	90%	No
Manual Handling - People	32	53	60.4%	90%	No
Immediate Life Support	7	N/A	N/A	90%	N/A

In urgent and emergency care the 90% target was met for two of the nine mandatory training modules for which qualified nursing staff were eligible. Immediate life support did not have any eligible staff recorded on the matrix; however, it was completed by seven members of staff.

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection Prevention (Level 1)	17	24	70.8%	90%	No
Fire Safety 3 years	16	24	66.7%	90%	No
Medicine management training	10	15	66.7%	90%	No
Basic Life Support	2	3	66.7%	90%	No
Health and Safety (Slips, Trips and Falls)	16	24	66.7%	90%	No
Information Governance	15	25	60.0%	90%	No
Infection Prevention (Level 2)	9	15	60.0%	90%	No
Manual Handling - Object	14	24	58.3%	90%	No
Immediate Life Support	1	N/A	N/A	90%	N/A

In urgent and emergency care the 90% target was not met for any of the eight mandatory training modules for which medical staff were eligible. Immediate life support did not have any eligible staff recorded on the matrix; however, it was completed by one member of staff.

Safeguarding

The service had safeguarding systems and processes in place to people from the risk of avoidable harm or abuse. However, safeguarding vulnerable adult and children level three training was not given sufficient priority. Safeguarding adults and children training rates for nursing and medical staff were low.

Staff we asked knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. However, we were not assured there was consistent knowledge across all staff groups. This was because not all staff had received information which had been shared around the ‘Think Family’ approach, exploitation, and baby safe initiatives. Staff told us demand on the department meant there was insufficient time to attend safeguarding training.

Staff we asked knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the unit. Reception staff had access to the Child Protection Information Sharing System (CPISS) and carried out a search of the system when each child was being booked into the department. An in-built system check meant that staff could not progress to discharge a child from the department unless a CPISS check had been carried out, documented, and a safeguarding children question completed.

Children and adults who were previously known to the safeguarding teams were highlighted by a flag on their electronic patient record. We understood that the trust's safeguarding children team undertook review of records of all children admitted via the emergency department.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff training completion rates exceeded the trust's target for safeguarding vulnerable adults and children training levels one and two in the year October 2018 to September 2019.

However, nursing training completion rates for safeguarding vulnerable children level three were very low; only 5.6% of eligible staff had completed this. Managers told us the service was working with the paediatric safeguarding team to offer bespoke training to staff with sessions offered between 7pm and 9pm. Staff told us only two registered paediatric nurses were compliant with safeguarding level three training; there were challenges to attend this training due to the demand on the service.

At the time of the inspection, the service did not deliver safeguarding vulnerable adults training; however, it was in the process of developing the training module and expected to start rolling this out to staff in February 2020.

Medical staff received training specific for their role on how to recognise and report abuse. However, medical staff training completion rates only exceeded the trust's target in one of the five training modules available. Medical staff nursing training completion rates for safeguarding vulnerable adults and children level one were low at 66.7% and safeguarding vulnerable children level one training completion rates were very low at 15.8%

Trust level

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	110	113	97.3%	90%	Yes
Safeguarding Children (Level 1)	97	101	96.0%	90%	Yes
Safeguarding Children (Level 2)	13	14	92.9%	90%	Yes
Safeguarding Adults (Level 2)	96	106	90.6%	90%	Yes
Safeguarding Children (Level 3)	5	90	5.6%	90%	No

In urgent and emergency care the 90% target was met for four of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	18	27	66.7%	90%	No
Safeguarding Children (Level 1)	16	24	66.7%	90%	No
Safeguarding Children (Level 2)	1	1	100.0%	90%	Yes
Safeguarding Adults (Level 2)	16	20	80.0%	90%	No
Safeguarding Children (Level 3)	3	19	15.8%	90%	No

In urgent and emergency care the 90% target was met for one of the safeguarding training modules for which medical staff were eligible.

Following our visit, we wrote to the trust to raise concerns about safeguarding children level three training rates for nurses and medical staff. The trust responded to clarify that this module had been added to the staff training requirements in summer 2019 following review of their scope of practice against the updated intercollegiate guidance issues in January 2019. The trust had placed a requirement for adult trained staff to undertake eight hours of safeguarding training, and twelve hours of training for paediatric staff, consultants, emergency nurse practitioners and assistant nurse practitioners. In its response, the trust also provided updated training figures. As at 18 March 2020, these were:

	SG L1 Adults	SG L2 Adults	SG L3 Adults*	SG L1 Children	SG L2 Children	SG L3** Children	SG L3*** Children
Registered Nurses	91.36%	84.48%	-	93.94%	86.36%	15.15%	73.77%
Medical Staff	100.00%	88.89%	-	100.00%	100.00%	27.27%	75.00%
All	98.86%	83.09%	-	93.75%	87.50%	16.67%	67.50%

* Figures not recorded. Work was in progress to scope what training is delivered at level 3.

** Eligible staff who were compliant with 8hrs+

*** Eligible staff who had accessed level three training but were not yet compliant at 8hrs+.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff inconsistently used equipment and control measures to protect patients, themselves and others from infection, although equipment and the premises were mostly observed to be visibly clean.

The emergency department had seven isolation rooms available; three legacy rooms and four new rooms that had been created since our last inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Except for the examples detailed below, most of the areas in the emergency department and clinical decision unit were visibly clean and had suitable furnishings which were clean and well-maintained.

However, the staff acknowledged the challenges in maintaining cleanliness and maintenance of the mental health interview and assessment room.

We observed vomit on the floor of one of the isolation rooms that had not been cleaned by staff for over an hour; it was cleaned after our intervention. We also observed another patient had soiled themselves in urine, and on the floor, and the patient had used their underclothing to clean the area. We observed the soiled underwear lying on the floor without being moved, or the area cleaned by staff. Separately, we observed there was a strong smell of stale urine within the patients' male toilet in the 'majors' unit.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). There were sufficient supplies of antibacterial hand-gel and personal protective equipment such as aprons and gloves throughout the department, and we observed these being used.

We observed staff following the ‘arms bare below the elbow’ protocol. However, between July 2019 and December 2019, the service achieved an average of 86% compliance with hand hygiene audits in the emergency department, and 78% compliance on the clinical decision unit.

(Source: Post inspection data request DR3b)

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed green ‘I am clean’ stickers were in use.

Between October 2019 and December 2019, an audit of infection prevention and control assessment in records in the emergency department indicated an average of 95% of records included assessment of infection prevention and control.

Compliance with infection prevention and control assessment in patients’ records was included in only three out of the four months (July, August, November and December) audit information was supplied by the trust for the clinical decision unit. This indicated an average of 86% of patient records included infection prevention and control assessment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always have sufficient equipment to undertake vital sign observations However, staff mostly managed clinical waste well.

The unit had been redesigned since our last inspection. Changes included a new adult waiting and triage room area, redesign of the paediatric waiting and treatment area, the addition of four new isolation rooms in the ‘majors’ unit, and extension of the ‘majors’ unit to provide an additional eight beds in bay cubicles. The changes provided a total of 24 assessment cubicles/rooms including the bays in the resuscitation area.

Walk-in patients were received in an open-plan reception area at the front of the department. Once booked-in by reception staff, patients were directed to the adult or paediatric waiting area as appropriate.

The adult waiting area was spacious, bright and appropriately decorated. There was sufficient seating for those waiting to be seen, although we observed the room to be busy during periods of heavy demand. The patient and visitor toilet in the waiting area had a ligature point; a metal coat hanger that was placed at a low level and which would be accessible to children.

There were four triage rooms located around the adult waiting area. One of these was used for assessment of patients that had been triaged into the primary care stream. Two triage rooms were used for general adult triage. The limited size of one of the triage rooms meant it was difficult to accommodate patients in wheelchairs. The remaining room was used for triage of patients attending with head injuries or chest pain.

Although there were wall alarms and panic buttons situated in the triage rooms, staff told us these were not connected to a central panel to indicate where a particular alarm has been activated. This meant that, in the event of an alarm activation, staff needed to check all areas of the department to find which room/area the alarm had been activated in.

We observed that alarms were not always located in an easily accessible place within the triage rooms; for example, a panic alarm was situated behind the computer screen in one triage room. In the priority triage room, the alarm was located on the opposite wall of the room from the staff desk and could be unreachable if a patient blocked staff access to it.

During our visit, there were periods of heavy demand on the service. Despite an increase in the number of cubicles within the 'majors' department since our last inspection, there were insufficient cubicles or bays to accommodate the number of patients attending during periods of high demand. We observed staff caring for patients in the ambulance corridor, the corridor leading to the clinical decision unit, outside a number of cubicles and on chairs throughout the adult department.

The service did not always have enough suitable equipment to help them to safely care for patients at times of heavy demand. Although the service allocated a 'corridor nurse' to care for patients waiting to be handed over or assessed, more than one staff member told us that equipment for taking vital sign observations, such as pulse oximeters, tympanic thermometers, and blood pressure cuffs, were not always available. One staff member described how they had to leave patients while they searched for available equipment. Another staff member described that paramedics often used their own equipment, or searched for equipment, to undertake observations while waiting with their patient. One patient told us that staff did not have the correct size of blood pressure cuff, and this was further corroborated by comments made independently to us by two staff members.

The mental health interview and assessment room was starkly decorated and contained a number of ligature points; on the handle of the keypad lock for the second exit door, on a boxed-in unit near adjacent to the main exit door, and on ceiling ventilation covers. This was not in line with the Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services 2020. We observed, and staff told us, that the lighting panels had been damaged previously by a patient using the room.

Although we were told that a department-wide ligature risk assessment had been carried out, we were not assured that it had identified all potential risks. We raised immediate concerns to the trust about the potential risks in the room.

Following our intervention, the trust provided a copy of the original ligature risk assessment. This was not sufficiently detailed to identify individual rooms, areas or cubicles, and relied solely on managing risks through individual risk assessments of mental health patients. (Our review of records indicated that risk assessments were not being undertaken.) The trust also took immediate action to carry out a further assessment using the Manchester Method for Anti-ligature Assessment and we noted, on our second visit, that work was underway to address the risks in the interview room.

In the majority of areas, the new assessment relied heavily on individual risk assessment of mental health patients as a control measure and it did not appear to fully consider risks to patients or carers attending the department who would not be covered by a mental health risk assessment; for example, non-breakable coat hooks in toilets, and curtain tie-back hooks in the relatives' room were not identified for replacement with a non-weight bearing versions.

The mental health interview and assessment room had one pull alarm panel situated close to the second exit door; however, there was a risk this could be inaccessible in an emergency if a staff member was blocked on the opposite side of the room by a patient.

The mental health interview and assessment room had two exit doors. The main door incorporated a picture window, which allowed observation of people within the room; however, the size of the window and location of the room meant that privacy for the people in the room was not maintained. This was not in line with the Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services 2020. Further, people in the room were able to look out onto the unit's busy co-ordination station; this was not conducive to helping those using the room to maintain a sense of calmness.

The second exit door was controlled by the use of a keypad lock that led into the adjacent sluice room. This raised a potential safety risk for anyone needing to leave the room by that door in an emergency. Furthermore, we observed the second door was blocked on the opposite site by a number of commodes. We raised this with staff at the time.

Patients could reach call bells, but staff were not always responsive when called. More than one patient told us they had used the call bell, but the call had not been responded to. During periods of high demand, there were no call bell facilities to enable patients waiting on trollies or chairs to call staff for assistance. A number of patients asked our inspection team for help or assistance as they had not been able to attract staff attention.

The paediatric waiting area was secure and required reception staff to grant remote access; however, it was in an open plan design where patients waiting to be seen were located close to the assessment cubicles and would be able to hear any distress from other patients.

Decoration within the paediatric department was, for the most part, child-friendly with bright colours and cartoon characters on the walls; however, for children being cared for in an assessment cubicle, their direct line of sight was towards a blank wall with no child-friendly decorations.

The mixed adults and children X-ray waiting area, although co-located to the emergency department, was stark and not particularly child friendly.

Exit points in the paediatric emergency department were accessible to adults and children. Although staff had a clear line of site from the nurses' station to the waiting area and the assessment cubicles, the ease of access and the sometimes low number of staff in the department meant there was a potential risk for children absconding. During our visit we observed that the main electronic doors to the paediatric emergency department opened automatically in the event of a fire alarm.

The 'Quiet Room' in the paediatric department was used for children attending the unit with mental health related symptoms. The room had two exit doors with appropriate observation windows and furniture; it was starkly decorated. However, there were no alarm systems within the room and staff did not have personal alarms. This was not in line with the Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services 2020. Limited numbers of plastic toys were available in the room, but these would be removed if a patient was awaiting assessment by the Healthy Young Minds Service (previously the Child and Adolescent Mental Health Service).

Although the main window at the front of the paediatric waiting area was obscured with a suitable design, we observed that adult patients and visitors used the immediate area outside the window to smoke and could be seen doing so from inside the waiting room.

The clinical decision unit accommodated up to eight patients in two four-bed single-sex bays. A further bay on the unit was used by therapy staff to undertake patient assessments.

The service had facilities that mostly meet the needs of patients' families. Two relatives' rooms were used, on occasion, for patients attending with mental health needs when the main interview and assessment room was already being used. One, at the end of the ambulance corridor, had multiple ligature points and materials that could be used as a ligature; such as a lamp with a lengthy electrical cord and roller-blind cords. The trust's ligature assessment, after our intervention, identified that this second room was to be taken out of use unit a full assessment could be carried out.

At the time of our visit, the trust was in the process of building an additional two computerised tomography (CT) scanners. This will provide additional scanning capacity to the two existing CT scanners.

The department had a decontamination room that could be used in the event of chemical, biological, radiation or nuclear (CBRN) contamination.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys were located across the adult and paediatric departments. A review of each trolley indicated that equipment held was, mostly, within the manufacturer's recommended expiry dates. We found one suction tube where the package was open, and we alerted staff to this.

Staff mostly disposed of clinical waste safely. Clinical waste was segregated and stored for disposal. We observed a number of sharps bins throughout the unit which had the date of construction marked. However, we observed that not all sharps bins were 'part closed' when not in use, and we observed one sharps bin in the resuscitation area that was clearly full and had tubing extruding from it.

Assessing and responding to patient risk

Staff did not consistently assess, monitor or manage risks to people who use the services. Staff did not complete risk assessments for mental health patients, meaning that opportunities to prevent or minimise harm were missed. They did not consistently minimise environmental and safety risks. However, staff identified and acted on patient early warning scores for patients whose conditions were deteriorating.

The assessment journey for walk-in patients commenced at reception, where navigational staff (commissioned by the trust but employed by a third party healthcare provider) streamed suitable patients to a primary care triage process or into the relevant adult or paediatric triage process. Patients attending with symptoms related to head injury or chest pain were given a red card and directed to red chairs located in the waiting room next to the entrance to the 'majors' unit.

The service used the Manchester triage system; this was designed to enable nurses to assign a clinical priority to patients, based on their presenting signs and symptoms, without making any assumption about the underlying diagnosis. Our review of records indicated that most 'walk-in' patients were triaged within 15 minutes of arrival; however, we there was a risk that this could be delayed during periods of heavy demand. For example, one response to a formal complaint showed that a paediatric patient with deteriorating symptoms waited for 45 minutes before being triaged.

Leaders told us the triage nurses were responsible for oversight of patients in the waiting area. However, we were not assured this was effective. There was no oversight of patients in the waiting area by the primary care navigator or by the reception staff. During our visits, we observed a number of patients in the waiting area that were clearly displaying symptoms of pain and/or distress. Of 14 patients in the waiting room we asked, none said they were given any information on what to do if their pain or symptoms worsened. We were also told by staff of a recent incident where a patient attempted to self-harm in the waiting area toilet.

Patients conveyed to the department by ambulance were directed to the two rapid assessment and triage cubicles at the front of the 'majors' unit.

Between January 2019 and December 2019, a total of 30,724 patients arrived by ambulance. Of these, 4,634 (15.3%) waited between 30 and 60 minutes for handover between the ambulance

crew and nursing staff. In the same period, 798 (2.6%) of patients waited over 60 minutes for handover to nursing staff.

Of all type one attendances between January 2019 and December 2019, 39,724 (39.5%) of patients were seen by a doctor within 60 minutes of arrival at the department. Over the same period, the data provided by the trust showed an overall deteriorating trend in the daily average per month of number of patients seen within 60 minutes of arrival from 121 patients in January 2019 to 77 patients in December 2019.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff used the national early warning score system (NEWS2) for adults, and the paediatric early warning score children (PEWS) for children. The scores were calculated electronically from the patient vital sign observations by staff and were displayed on the department's patient dashboard, which enabled staff to prioritise the sickest patients.

Our review of records indicated that vital sign observations were mostly being carried out as expected and nursing staff escalated care to doctors accordingly where patients appeared to be deteriorating.

Between October 2019 and December 2019, an audit of patient observations in records in the emergency department indicated an average of 85% of records included patient observations. For the clinical decision unit, the information provided by the trust included data for compliance with patient observations for three of the four months supplied. This indicated an average of 77% compliance with recording of patient observations. This was an improvement on the results of an audit of vital signs observation between January 2018 and January 2019 which indicated that 46% of patients had received a vital sign observation within 15 minutes of arrival with 54% having their observations reassessed within 60 minutes.

Staff completed clinical risk assessments for each patient on admission / arrival and reviewed these as required, including after any incident. While our review of records indicated that staff undertook a range of risk assessments during triage, including risk of falls and the risk of developing pressure ulcers (the Anderson scale), the service's audit results (as explained in the safety thermometer sub-heading, showed limited compliance with undertaking risk assessments).

Through our review of serious incidents between 1 January and 1 March 2020 we found that there had been two serious incidents reported for the emergency department which related to pressure ulcers meeting serious incident criteria. The route cause analysis investigations had not yet been completed.

We did not find any evidence that staff undertook nutritional assessments.

We found no evidence that staff were undertaking the patient safety checklist. The checklist was designed to ensure all relevant actions and assessments were completed at appropriate times within each hour of attendance. Staff told us they were reluctant to use the form as the length of it, and time taken to complete it, was cumbersome particularly during busy times.

We escalated this to the trust. It took immediate action to redesign the checklist with input from band five staff. During our second visit we observed that the new checklist was in place and being used. However, we observed there were a number of inconsistencies in how the form was being completed, which could lead to confusion and loss of assurance. For example, some staff were completing the list with ticks/crosses, yes or no, or strikethrough lines. This meant it was not always clear if an individual check had been completed or could not be completed; for example, if the patient was asleep. Inconsistent completion of the new checklist was noted within the senior nurse audits being carried out following the re-launch of the form.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The mental health liaison team aimed to see 75% of all referrals from the emergency department within one hour of the patient's arrival, and 95% within two hours of arrival. Referral to the team was by the internal bleep system, although the service was looking to introduce an electronic referral system in the future.

Our review of records indicated that although staff referred patients presenting with mental health symptoms to the mental health liaison team, they did not complete risk assessments for these patients. Out of five records we reviewed during our first visit, none had risk assessments or observation completed by staff. The service could not therefore provide assurance that staff were aware of any relevant risks to patients, or others, while patients were awaiting review by the mental health liaison team.

We intervened with the trust on this, in conjunction with our concerns about ligature risks in the department. During our second visit, we found the service had introduced standard risk assessment forms which had been completed, albeit to a variable standard (not all had completed a risk score) and were subsequently scanned to patient records. We noted the form was dated from 2012.

The service told us that children and young people under the age of 16 who present to the paediatric emergency department with mental health symptoms were initially assessed by emergency department and paediatric staff. A decision would then be made on whether the patient should be admitted to the paediatric ward for a mental health assessment by the Health Young Minds Stockport service (formerly the child and adolescent mental health service). Assessment by the mental health team would usually be carried out the following working day (or when the patient was deemed to be medically fit) by the mental health service. If a child or young person was discharged, the discharge notes were reviewed by the safeguarding children's team within 24 hours of discharge, or 72 hours if the discharge was at the weekend.

However, our review of records also indicated inconsistency in the risk assessment of children carried out in the emergency department for those children subsequently referred to the ward for further assessment by the mental health service. In two of the three records we reviewed, the risk assessments were inconsistently completed.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Discharge summaries to GPs were electronically generated.

Emergency Department Survey 2018 – Type One A&E departments

The trust scored about the same as other trusts for each of the five Emergency Department Survey questions relevant to safety.

Question	Trust score	RAG
Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	7.4	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.0	About the same as other trusts
Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.1	About the same as other trusts
Q33. In your opinion, how clean was the A&E	8.4	About the same as other

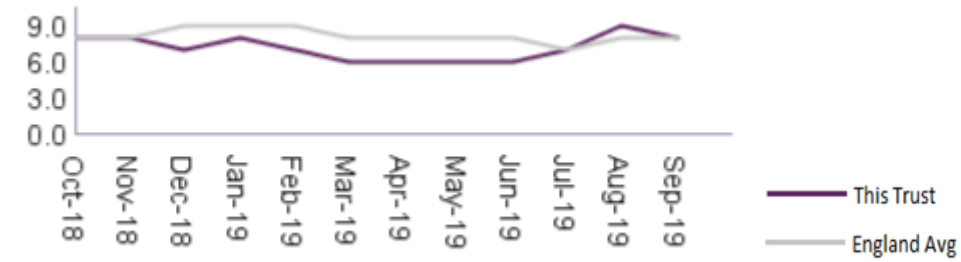
department?		trusts
Q34. While you were in A&E, did you feel threatened by other patients or visitors?	9.5	About the same as other trusts

(Source: Emergency Department Survey 2018)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median in seven months over the 12 month period from October 2018 to September 2019.

Ambulance – Median time to initial assessment from October 2018 to September 2019 at Stockport NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Stepping Hill Hospital Stockport Greater Manchester

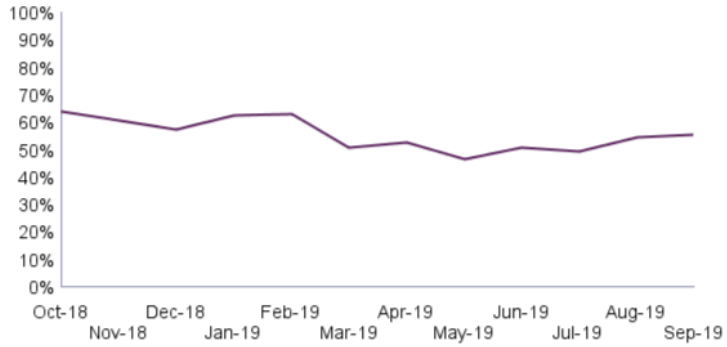
From October 2018 to September 2019 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Stepping Hill Hospital Stockport Greater Manchester decreased (improved) from 63.9% in October 2018 to 55.5% in the most recent month reported.

Data provided by the trust after the inspection that, between January 2019 and December 2019, 30,219 patients arrived by ambulance. Of these, 4634 (15.3%) patients waited between 30 and 60 minutes for handover. A further 798 (2.6%) waited for more than 60 minutes for handover.

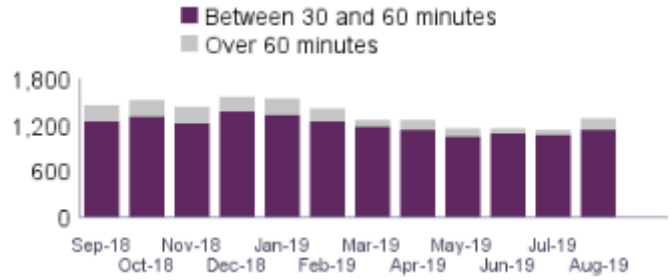
(Source: Post inspection additional data request DR1)

Staff told us that the paediatric emergency department did not receive pre-alerts from the ambulance service unless the child was critical.

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Stepping Hill Hospital Stockport Greater Manchester



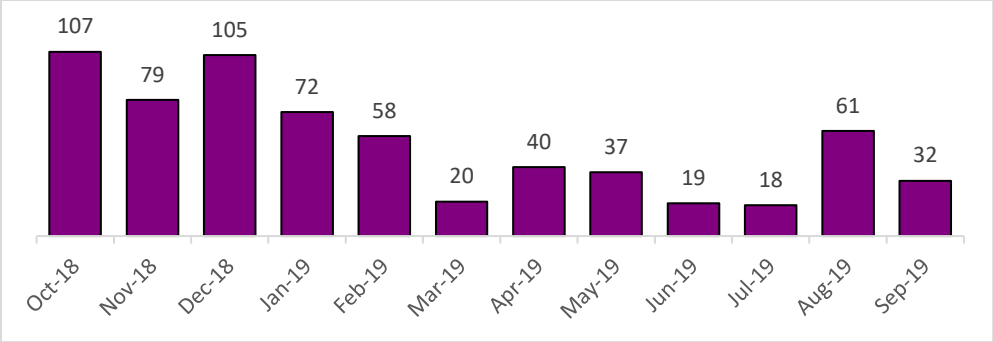
Ambulance: Number of journeys with turnaround times over 30 minutes - Stepping Hill Hospital Stockport Greater Manchester



(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From October 2018 to September 2019 the trust reported 648 “black breaches”. Of these breaches, 56% occurred between October 2018 and January 2019.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Data provided by the trust after the inspection that, between January 2019 and December 2019, 30,219 patients arrived by ambulance. Of these, 798 (2.6%) waited for more than 60 minutes for handover.

(Source: Post inspection additional data request DR1)

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment at all times, and particularly during periods of heavy demand on the service. However, managers gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe at all times, including during periods of high demand. Following our visits, we wrote to the trust to outline our concerns about staffing levels.

The service had reviewed nurse staffing levels in June 2019. The new model focussed on reducing the number of band two healthcare assistant staff and increasing the number of band six nursing staff.

The actual number of nurses and healthcare assistants in post, at the time of the inspection, did not match the planned numbers. The planned establishment, actual numbers of staff in post and the number of vacancies by whole time equivalent (WTE):

Staff Group	Planned	Actual	Vacant posts

	Establishment (WTE)	(WTE)	(WTE)
Band 2 Healthcare Assistant	10.56	8.56	2.0
Band 3 Senior Healthcare Assistant	19.82	19.32	0.5
Band 5 Staff Nurse	60.29	37.49	22.8
Band 6 Sister / Charge Nurse	23.4	19.02	4.38
Band 7 Senior Sister / Charge Nurse	8.78	5.78	3
Total	**122.85**	**90.17**	**32.68**

Recruitment to the vacant posts was ongoing with the roles out to advert or applicants were undergoing the interview/appointment stage. This included ten WTE international band five nurses who were expected to be in post by March 2020, and the appointment of 2.6 WTE band seven staff.

The service was looking to introduce four nurse associate roles within the department. Thirteen applicants had been shortlisted and two had been recruited but, at the time of inspection, it was not known when the staff would be in place.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in the emergency department (which included the paediatrics department). The planned staffing was scheduled over a long day shift, late shift, and a night shift, with 17 registered nurses and six healthcare assistants for each shift.

The establishment was calculated to maintain a patient to nurse ratio of at least 1:4, and a healthcare assistant to patient ratio of at least 1:8. However, more than one staff member told us the department was regularly short staffed with nurses caring for between eight and ten patients and healthcare assistants caring for up to 15 patients. Staff commented that the extremely high demand seen during our visit to the department was 'normal.'

We reviewed the nurse staffing rotas from 4 November 2019 through to 23 January 2020. These indicated the service relied heavily on bank and agency staff on a daily basis to support the permanent staff; only four shifts out of 252 during that period were not supplemented by bank or agency staff. In the same period, only 31 out of the 252 shifts met the planned establishment of 17 registered nursing staff (permanent and bank/agency staff combined).

None of the 252 available shifts met the planned established of 17 permanent registered nurses, and we noted a number of shifts where the permanent establishment was as low as five registered nurses (for example, the night shift on 23 November 2019) and six registered nurses (for example, although not limited to, the night shift on 22 November 2019, the late and night shift on 1 December 2019 and the early and late shift on 26 January 2019).

(Source – Post inspection data request DR20)

On the Monday morning of our second visit, the service had significantly low numbers of nursing staff. Against the planned staffing level of 17 registered nursing staff and six healthcare assistants, the service had been expecting 12 nursing staff. However, due to a number of cancellations, co-ordination staff told us on our arrival they had eight nurses and two healthcare assistants. At this point, there were 50 patients in the department, 17 of which were to be admitted to a hospital bed, and a further nine patients were waiting in the corridors. We raised the staffing levels with the service's senior leaders, who told us that staffing levels for the late shift had been escalated.

However, although the service's leaders indicated that the escalation policy had been followed, this was not evident to the inspection team, who only observed additional staff appearing after our concerns were raised.

Although demand on the service was not quite as heavy as on the previous visit, we observed numerous deficiencies in basic care provision to patients that day as a result of the low staff numbers. This included, but was not limited to, staff not maintaining a patient's privacy and dignity, urine and vomit spills not being cleaned, staff not responding to patient call bells, and lack of monitoring of pain scores.

Staffing for the clinical decision unit was managed with the staffing for the ambulatory care unit and consisted of one band seven registered nurse and two healthcare assistants per shift. An additional band five registered nurse was allocated to the unit from the wards at times when the unit was required to care for medical patients awaiting a bed on the wards.

Staffing in the paediatrics emergency department was not in line with the workforce standards in the Royal College of Paediatrics and Child Health's guidance document, Facing the Future: Standards for children in emergency healthcare settings, published in June 2018. Standard ten states: "Every emergency department treating children must be staffed with two registered children's nurse." Standard eleven states: "A minimum of two children's nurses per shift in dedicated children's emergency departments must possess recognisable post-registration trauma and emergency training."

We reviewed the paediatric staffing rota for 4 November 2019 through to 26 January 2020. There were 84 shifts each of early, late, twilight and night shifts. Only 48% of early and late shifts had two paediatric trained staff, or two paediatric trained staff plus one supernumerary staff member. For twilight shifts, this dropped to 2%, and for night shifts only 36% had two paediatric trained staff.

(Source: Post-inspection data request DR20b)

Staff in the paediatrics department told us the planned establishment should be 11 WTE staff, comprising of one band seven supported by a mix of band six and band five staff. Staff told us their staffing capacity was 'down' by seven WTE. Staff told us they were aware of ongoing recruitment of newly qualified paediatric trained staff, but they were not due to be in post until April 2020. At the time of the inspection, there were 2.6 WTE paediatric trained registered nurse vacancies, 1.96 WTE paediatric trained registered nurses on maternity leave with an additional 1 WTE due to imminently commence maternity leave, and 0.64 WTE on short term sick absence.

As such, staff said it was a challenge to maintain the requirement of two paediatric trained registered nurses per shift, and staff were regularly working extra hours on bank shifts. This comment was validated by similar comments made by the service managers. On two occasions during the inspection, we visited the paediatric emergency department and noted the department was unstaffed for brief periods as the only available staff were elsewhere, such as in the treatment room.

On one of these occasions two patients, who had presented with mental health related self-harm risks, were in the assessment cubicles in the department. On the second occasion, the staff member had been attending to a patient in the treatment room while there were patients waiting in the assessment cubicle and in the waiting room. The staff member told us they were the only person on duty at that time.

We reviewed the children's emergency department shift reports. The shift reports recorded the names of the staff members on duty and were designed to enable staff to record the average wait

time, the number of patients waiting to be seen, the number of patients in the department, and the number of patients scoring greater than two on the paediatric early warning score system every two hours.

We reviewed the shift report on 30 January 2020 at the time of this second event; this showed only one nurse as on duty for the long day shift. Review of previous shift reports showed that of the previous seven days, only three long day shifts, one twilight shift, and one night shift had two paediatric registered nurses on shift. Further, on five separate days, staff had recorded periods on the shift report where they were too busy to complete the required metrics.

Nurse staffing handovers took place twice a day. These included a group 'safety huddle' led by a senior nurse, followed by individual handovers. The huddle involved all staff and was an opportunity for information to be passes on about changes to practice and roles that day.

Individual nurse handovers completed individual handovers about each patient under their care. The handovers contained details of the patients' individual and clinical needs.

Trust level

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at trust level compared to the trust's targets, where applicable:

	Urgent and emergency care annual staffing metrics						
	October 2018 – September 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	14%	3.5%			
All staff	275.3	22%	30%	5.1%			
Qualified nurses	136.7	23%	32%	5.6%	34,678	9,948	N/A

We were unable to calculate bank/agency usage as a percentage of the total number of hours available as this information was not provided by the trust. Similarly, there was no data provided for unfilled hours. We asked the trust for total number of unfilled shifts for this period; however, we did not receive this information.

Vacancy and turnover rates for nursing staff in urgent and emergency care was more than double the trust target for these metrics.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Medical staffing

The number of medical staff in the service did not match the planned number; however, the service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The number of medical staff in the service did not match the planned number; however, the service had enough medical staff to keep patients safe. The service had ten consultants in

emergency medicine, with three whole time equivalent vacancies. Medical staff we asked acknowledged the challenges surrounding the nursing staff numbers; however, they were confident there were sufficient numbers of consultants, specialists and junior doctors to maintain safe medical care.

Consultant staff numbers were sufficient to ensure 16 hours a day consultant cover; this was in line with the Royal College of Emergency Medicines' Workforce Recommendations 2018.

Consultant cover was provided on-site between the hours of 8am and 10pm Monday to Friday with on-call consultant cover provided out of hours. Consultant cover was provided on-site between 8am and 7pm, with a further weekend on-call consultant outside these hours.

We reviewed the consultant rota from 1 December 2019 to the point of the inspection and forward through the planned rota to March 2019. We did not identify any gaps in the rota, although we noted the consistent use of a locum consultant for the weekend 11am to 7pm shift.

The middle, registrar and junior grade doctor rota for the same period indicated there was a senior doctor of grade ST4 or above on duty overnight.

Trust level

The table below shows a summary of the medical staffing metrics in urgent and emergency care at trust level compared to the trust's targets, where applicable:

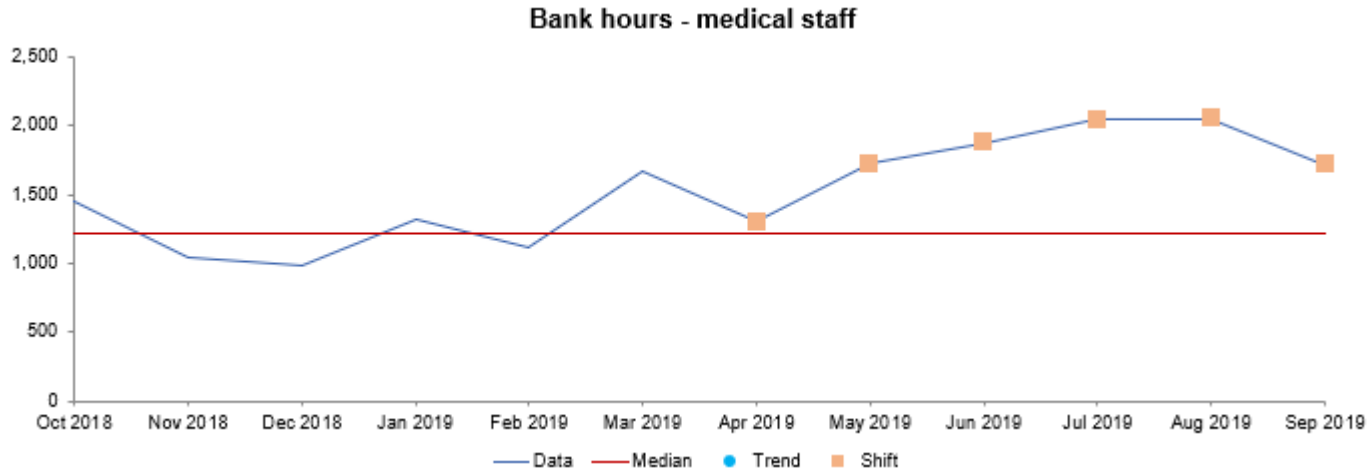
	Urgent and emergency care annual staffing metrics						
	October 2018 – September 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	14%	3.5%			
All staff	275.3	22%	30%	5.1%			
Medical staff	41.5	37%	45%	0.8%	18,145 (45%)	10,288 (26%)	11,777 (29%)

Vacancy and turnover rates were more than triple the trust target is for these metrics.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and locum use.

Monthly bank use over the last 12 months for medical staff show an upward shift from April 2019 to September 2019.



Managers could access locums when they needed additional medical staff. The consultant rota indicated consistent locum use for late morning through to early evening weekend shifts.

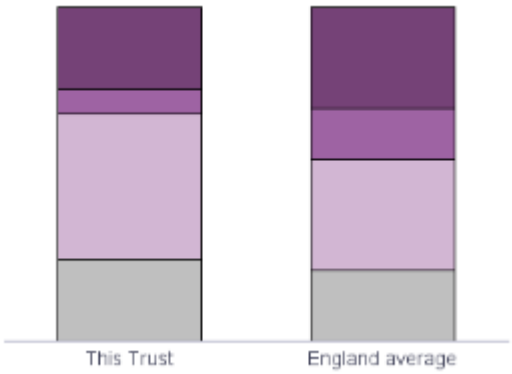
Managers made sure locums had a full induction to the service before they started work.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In June 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 28 whole time equivalent staff working in urgent and emergency care at Stockport NHS Foundation Trust.



	This Trust	England average
Consultant	25%	30%
Middle career^	8%	15%
Registrar group~	43%	33%
Junior*	25%	21%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. However, all staff had access to an electronic records system that they could all update. Records were clear, stored securely and easily available to all staff providing care.

Patient records were predominantly electronic and securely stored on the emergency departments electronic patient record. Notes were clearly structured with staff names and timestamps recorded

automatically. Medicines were prescribed, and administration recorded, on the electronic prescription and medicine administration system. Vital sign observations were clearly recorded on the system and early warning scores were automatically calculated and recorded from these.

Staff throughout the department were able to access the password protected records. Any paper documents used during patients' care and treatment were subsequently scanned onto their electronic records.

Read-only access to patients' emergency department records was available to other specialisms with the hospital; however, staff told us they were not confident that staff in other departments made regular use of, or accessed, the records available to them.

Discharge summaries for GPs were electronically generated through, and stored, on the system.

We reviewed 41 patient records during our visits; these included five records of adult patients and three records of children attending the service with mental health symptoms.

During our first visit, staff told us that the patient safety checklist was not being used. Our review of records at that time confirmed this to be the case. We raised it with managers who told us staff had concerns with the design of the form and were reluctant to use it. We escalated this to senior leaders on site and subsequently wrote to the trust to raise our concerns.

During our second visit we observed that safety checklists were in place and being used. Managers told us the checklist had been simplified in consultation with band five nursing staff. We looked at a random sample of four checklists for patients in the unit that day; there was some variability in the method of completion; for example, some staff were writing yes and no, other staff were marking with ticks or lines. This variability raised the risk of misinterpretation. Staff we asked told us the new forms had been implemented rapidly in the middle of a shift and staff had not been given any specific training or direction on how to complete the forms.

During our first visit, for patients attending with mental health symptoms, we found no evidence of any risk assessments or physical observations on their electronic record during the period between being referred to, and subsequently being assessed by, the mental health liaison team. Staff told us they did not undertake further observations of the patient while waiting for the liaison team. We were not, therefore, assured of the safety of such patients; we escalated this to senior leaders on site and subsequently wrote to the trust to raise our concerns.

A further three paediatric records for patients that had been admitted via the emergency department to the trust's paediatric ward, while waiting for a Healthy Young Minds assessment, showed no evidence of a risk assessment within the emergency department.

During our second visit, we observed that, in response to our concerns, the trust had implemented a mental health safety risk assessment checklist. We reviewed an additional five records during this visit for adult patients that had attended the department in the previous few days.

The five care records post inspection all had a mental health risk assessment completed immediately after entering the emergency department and before they had a formal mental health assessment by the mental health liaison team. All these had a mental health risk assessment. However, as this had only been implemented in the previous week we cannot yet say that the process was fully embedded.

Between October 2019 and December 2019, an audit of patient record documentation in the emergency department indicated an average of 100% of records were compliant. For the clinical decision unit, audit of documentation compliance was included in two out of the four months (July,

August, November and December) information supplied. This indicated a 75% compliance with documentation requirements.

(Source – post inspection additional data request DR3)

Medicines

The service used systems and processes to safely prescribe, administer, and record medicines. The system for assurance on the storage of temperature sensitive medicines was not always effective.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were prescribed on an electronic prescribing system, which staff used to record administration of medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines.

Medicines management was a standing agenda item at the division's urgent care quality assurance meeting

Between October 2019 and December 2019, an audit of medicines assessment in records in the emergency department indicated an average of 99% of records included assessment of patients' medicinal needs.

For the clinical decision unit, compliance with medicines assessment was included in three out of the four months (July, August, November and December) for which information was supplied. This indicated an average of 95% of records included a medicines assessment.

(Source – post inspection additional data request DR3)

Staff mostly stored and managed medicines in line with the provider's policy. We reviewed a random sample of medicines and fluids stored in the department and saw that all were within their respective manufacturers' recommended expiry dates. Bottles of liquid medicines were marked with the date of opening; the trust worked to a 10% wastage level for liquid medicines.

Medicines that were temperature sensitive where stored in fridges throughout the department. Typically, such medicines need to be kept at between two and eight degrees Celsius. Exceeding the limits can impact on medicines' effectiveness and may require medicines to be disposed of or have their recommended expiry dates reduced.

We reviewed the fridge temperature checklists throughout the department. There were some gaps in the recording of temperatures. However, we also noted that staff only recorded the actual temperature of the fridge at the time of checking; staff did not record the maximum or minimum temperatures for each fridge. There were processes in place for staff to contact pharmacy in the event of a temperature being out of range. However, the lack of checking/recording of the maximum and minimum ranges meant that staff could not be assured that the temperature limits had not been exceeded and, as such, could not be assured of the effectiveness of the medicines.

The service was supported by a pharmacy technician, Monday to Friday. The technician reviewed and updated stock held within the department and managed the 'to take home' TTO medicines to reduce the time patients waited for medicines before being discharged.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The trust's antimicrobial snapshot audit in 2019 showed that the integrated care division achieved 96% compliance with prescribing antibiotics in line with the trust's guidelines or as recommended by the microbiologist, and 82% of prescriptions for longer than 24 hours had been reviewed.

Incidents

The service did not consistently manage patient safety incidents well; staff recognised but did not always reported incidents and near misses. However, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we asked knew what incidents to report and how to report them. However, we were not assured that staff always raised concerns and reported incidents and near misses in line with trust/provider policy.

The service's emergency department operational meeting minutes for 15 January 2020 recorded that the incident reporting numbers were low, and that staff were to be encouraged to report incidents as they occurred.

Some staff told us they did not always report incidents, such as unavailability of equipment, as they had no confidence it would make a difference.

Managers investigated incidents. Patients and their families were involved in these investigations. We reviewed five serious incident investigation reports and action plans. They were comprehensive and included detailed recommendations and action plans for improvement.

Staff told us they received some feedback from investigation of incidents that occurred in the department during safety huddles and meetings; however, staff we asked could not recall receiving feedback about incidents that occurred elsewhere in the hospital.

Staff understood the principles of duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The duty of candour is a regulatory duty that requires a health service provider, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body, to notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

Never events

Managers shared learning about never events with their staff and across the trust.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust reported no never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

However, the service reported one never event in October 2019. This related to an overdose of insulin as a result of using an incorrect device. We reviewed the serious incident root cause

analysis investigation report and action plan, which detailed how learning from the incident was to be shared across the trust. Learning from the incident, including updated policies and procedures was shared with staff in the emergency department's safety huddle, and also included in the safety huddle folder for staff to read.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 64 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2018 to September 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	51	79.7%
Major incident/ emergency preparedness, resilience and response/ suspension of services	4	6.3%
Pressure ulcer meeting SI criteria	3	4.7%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2	3.1%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	1.6%
Incident affecting patient's body after death meeting SI criteria	1	1.6%
Abuse/alleged abuse of adult patient by staff	1	1.6%
Slips/trips/falls meeting SI criteria	1	1.6%
Total	**64**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

Staff collected safety thermometer information and shared it with staff, patients and visitors. However, the service's audit of records indicated low average compliance with falls, tissue viability and catheter care assessments in the emergency department.

Safety thermometer data was displayed on the unit for staff and patients to see.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The safety thermometer showed the service had reduced the incidence of harm within the reporting period.

Data collection takes place one day each month - a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer (August 2019), one fall with harm (March 2019) and no new urinary tract infections in patients with a catheter from August 2018 to August 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Between October 2019 and December 2019, an audit of falls risk assessment in records in the emergency department indicated an average of 33% (low 10% to high 61%) of records included assessment of patients' falls risk.

Compliance with falls risk assessments on the clinical decision unit for the four months (July, August, November and December) where the trust provided data, indicated that an average of 71% (low 39% to high 100%) of patients had received a falls risk assessment.

Between October 2019 and December 2019, an audit of tissue viability assessment in records in the emergency department indicated an average of 52% (low 31% to high 75%) of records included tissue viability assessment.

Compliance with tissue viability assessments on the clinical decision unit for the four months (July, August, November and December) where the trust provided data, indicated that an average of 86% of patients had received a tissue viability assessment.

Between October 2019 and December 2019, an audit of catheter care assessment in records in the emergency department indicated an average of 67% (low 33% to high 100%) of records included catheter care assessment.

Information provided by the trust (for July, August, November and December) on the quality metrics audit for the clinical decision unit did not include any figures relating to catheter care assessment.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

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

Through the trust intranet, staff had access to evidence-based guidance such as the Royal College of Emergency Medicine, the Royal College of Paediatric Emergency Medicine, the National Institute for Heath and Care Excellence, and professional bodies such as the British Thoracic Society, and the European Society of Cardiology.

Staff were alerted to the introduction of new or updated guidance and pathways during the safety huddle and in team meetings.

Nutrition and hydration

Staff did not always give patients food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. However, there was no system in place for identifying and assisting patients who needed additional help to eat and drink.

Staff did not use a nationally recognised screening tool to monitor patients at risk of malnutrition. Our review of patient records indicated that staff did not routinely undertake assessment of patients' nutritional status or fluid status. Staff we asked about this confirmed that screening tests

were not usually carried out in the department, including for those patients in the department for lengthy periods while waiting for an admission bed.

Between October 2019 and December 2019, an audit of nutrition assessment in records in the emergency department indicated an average of 66% of records included assessment of patients' nutritional needs.

During our second visit, one patient in the emergency department was receiving nutrition via a percutaneous endoscopic gastrostomy (PEG) feeding tube. Doctors on the unit prescribed the specialist feed. Staff had received training on the use of feeding pumps and were supported in the administration of feed by the clinical practice facilitator.

We observed volunteers offering patients hot and cold drinks and sandwiches during our inspection. Several staff told us of one particular volunteer without whom patients in the corridor would not have received food and drink.

However, we were not assured, that staff always make sure patients had enough to eat and drink. This was because there was no process, such as the use of coloured trays and jugs, to identify patients who needed additional help with eating or drinking. We asked the managers about this, who told us staff relied on visitors, carers and volunteers to help such patients.

Vending machines, providing a range of snacks and drinks, were situated in the waiting area.

Emergency Department Survey 2018 – Type 1 A&E Departments

In the CQC Emergency Department Survey, the trust scored 6.8 for the question "Were you able to get suitable food or drinks when you were in the emergency department?". This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Pain relief

Staff assessed and mostly monitored patients to see if they were in pain and gave pain relief. However, during periods of heavy demand staff did not always recognise or respond to patients expressing distress due to pain.

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately; this was reflected in our review of records during the inspection.

However, our observations during our visits in the emergency department at periods of heavy demand and staff shortages, meant that we were not assured that staff were always able to respond quickly to patients who were experiencing pain. Our inspection team noted several examples of people in the waiting room, and in the emergency department, expressing pain or crying as a result of pain, who were waiting for staff to respond to their requests for help.

Between October 2019 and December 2019, an audit of pain assessment in records in the emergency department indicated an average of 92% of records included assessment of patients' pain.

Although the trust sent details of a range of quality metrics for the clinical decision unit, compliance with pain assessment was only included in one out of the four months information supplied. In July 2019, audit of the records showed that 75% of patients in the clinical decision unit had their pain assessed.

(Source: Post inspection additional data request DR3)

Emergency Department Survey 2018 – Type One A&E Departments

In the CQC Emergency Department Survey, the trust scored 7.6 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Patient outcomes

Staff monitored the effectiveness of care and treatment. Patient outcomes were not always positive or met expectations in line with national standards, but they used the findings to recommend improvements. The service's frailty intervention team and functional risk equipment social and home environment team achieved positive results for admission avoidance through deflection of patients back home after assessment.

Managers and staff used audit results to understand patient outcomes. Managers shared and made sure staff understood information from the audits. For example, audits were carried out in the emergency department for the management of spontaneous pneumothorax, and hand injury, diagnosis of deep vein thrombosis, and community acquired pneumonia. All audits identified areas for improvement and made recommendations for learning.

The service participated in relevant national clinical audits; for example, the Royal College of Emergency Medicine audit. However, outcomes for patients were not always positive or met expectations in line with national standards. For example, the service undertook an audit in August 2019 of performance against the Royal College of Emergency Medicine's standards for the vital signs in adults.

The audit results indicated that the service achieved 35.4% compliance (against a national mean compliance of 49.7%) against the 15 minute standard for recording vital sign observations. The service achieved 30.8% compliance (against a national mean of 54.2%) for the 60 minute standard for repeat review and recording of abnormal vital signs. However, the service achieved 100% compliance for the recognition of abnormal vital signs by a clinician (against a national mean of 71.7%) and 100% compliance for acting on abnormal vital signs (against a national mean of 71.8%).

The audit recognised the increased demand on the service and congestion in the 'majors' unit as a contributary factor. It recommended improved streaming to the right categories, reducing the number of nursing vacancies, improving the nursing skill mix and increasing the number of nurses trained in triage, and subsequent re-audit in April 2020.

Further, in August 2019's audit of performance against the Royal College of Emergency Medicine's standards for venous thromboembolism (VTE) risk in lower limb immobilisation, showed mixed results. The service was 50% compliant (against a national mean of 53%) in the first standard to demonstrate written evidence of VTE and bleeding risk assessment in the emergency department. In the second standard, to demonstrate written evidence of a patient information leaflet being given the service was 46% complaint (against a national mean of 30%). In the third standard, which related to evidence of thromboprophylaxis medicine administration being commenced in the emergency department (when prescribed), the service was 6% complaint against a national mean of 23%.

The audit made a number of recommendations, including updating the service's electronic patient record system to make recording of evidence to show compliance against the three standards mandatory fields. A re-audit was recommended for May 2020. However, the service's audit in August 2019 of performance against the Royal College of Emergency Medicine's standards for the feverish child, the service generally performed better than the national mean. For example, in the second standard relating to assessment of a feverish child's risk of sepsis, the service was 92.2% compliant against a national mean of 36.1%. In the third standard relating to the child being assessed in line with the National Institute for Health and Care Excellence's guidance for a 'traffic light' system, the service was 100% compliant (against a national mean of 71.6%). Although performing well, the audit recognised the impact of peak activity and time pressure on initial triage assessment, clear escalation processes, and education and an appropriate action plan had been put in place around these.

(Source: Post inspection data request DR6)

Between June 2019 and February 2020, the service's functional risk equipment social and home environment team (FRESH) teams enabled 592 patients to return home from the emergency department rather than being admitted to hospital, and a further 401 patients were returned home from the clinical decision unit after assessment.

Between November 2019 and February 2020, the service's frailty intervention team (FIT) assessed 554 patients attending the emergency department. Of the 360 patients where outcome was recorded, 36.7% were discharged home and 7.5% were discharged to other intermediate or 'step-down' care providers; 55% of those remaining in hospital were admitted to short-stay wards such as the acute medical unit or the short stay for older people's ward (SSOP). Analysis provided by the trust indicated assessment by the FIT team had led to an improvement of patients' length of stay in hospital. For all patients seen by the team, the overall length of stay reduced from nine to eight days; while the length of staff excluding 'zero-day length of stay patients' reduced from 12 to 10 days.

RCEM Audit: Moderate and acute severe asthma 2016/17

Stepping Hill hospital

The table below summarises Stepping Hill hospital's performance in the 2016/17 RCEM moderate and acute severe asthma audit. The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Hospitals	Met national standard?
Standard 1a: O2 should be given on arrival to maintain sats 94-98%.	34.0%	Better	Not met
Standard 2a: Vital signs should be measured and recorded on arrival at the emergency department.	40.0%	Similar	Not met
Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department.	60.0%	Better	Not met
Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist	89.7%	Better	Not met

bronchodilator therapy.			
Standard 5a: If not already given before arrival to the emergency department, steroids given within 60 minutes of arrival (acute severe).	14.3%	Similar	Not met
Standard 5b: If not already given before arrival to the emergency department, steroids given within four hours of arrival (moderate).	16.3%	Similar	Not met
Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines.	88.9%	Better	Not met

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Stepping Hill hospital

The table below summarises Stepping Hill hospital's performance in the 2016/17 RCEM consultant sign-off audit. The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other Hospitals**	**Met national standard?**
Percentage of patients from high-risk groups reviewed by a consultant in Emergency Medicine prior to discharge from the Emergency Department:			
Atraumatic chest pain in patients aged 30 years and over.	10.0%	Similar	Not met
Fever in children under 1 year of age.	5.6%	Similar	Not met
Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.	2.0%	Worse	Not met
Abdominal pain in patients aged 70 years and over.	4.0%	Worse	Not met

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Stepping Hill hospital

The table below summarises Stepping Hill hospital's performance in the 2016/17 RCEM Severe sepsis and septic shock audit. The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other Hospitals**	**Met national standard?**
Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.	52.0%	Similar	Not met
Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED.	70.0%	Similar	Not met
Standard 3: O2 was initiated to maintain	64.3%	Better	Not met

SaO2>94% (unless there is a documented reason not to): Within one hour of arrival.			
Standard 4: Serum lactate measured: Within one hour of arrival.	80.0%	Better	Not met
Standard 5: Blood cultures obtained: Within one hour of arrival.	64.0%	Better	Not met
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival.	60.0%	Better	Not met
Standard 7: Antibiotics administered: Within one hour of arrival.	72.0%	Better	Not met
Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival.	40.0%	Better	Not met

(Source: Royal College of Emergency Medicine)

Trauma Audit and Research Network (TARN)

Stepping Hill hospital

The table below summarises Stepping Hill hospital's performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

Metrics ***(Audit measures)***	**Hospital performance**	**Audit Rating**	**Met national standard?**
Case Ascertainment *(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)*	100+%	Good	Met
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury *(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)*	56 mins	Takes longer than the TARN aggregate	Met
Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury *(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding*)	60.0%	Lower than the TARN aggregate	N/A
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care *(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)*	0.0%	Lower than the TARN aggregate	Did not meet
Risk-adjusted in-hospital survival rate following injury (*This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly*	1.7 additional survivors	As expected	Met

against those with a less complex case mix.)			

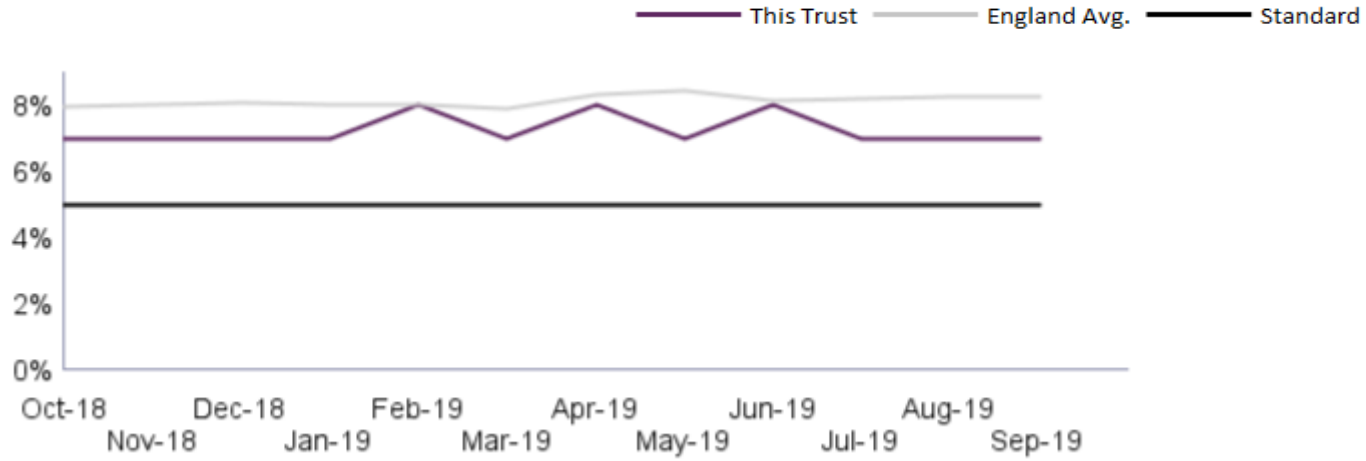
(Source: TARN)

Unplanned re-attendance rate within seven days

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

From October 2018 to September 2019, the trust's unplanned re-attendance rate to the emergency department within seven days was worse than the national standard of 5%. Trust performance had been better than the England average from August 2018 to January 2019; however, it had started to fluctuate between 7% and 8% which is similar to the England average.

Unplanned re-attendance rate within seven days - Stockport NHS Foundation Trust



(Source: NHS Digital – A&E quality indicators)

Competent staff

The service could not assure itself that staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

We could not be assured that nursing staff were experienced and had the right skills and knowledge to meet the needs of patients. This was because, although we did not find any evidence during our visits to indicate that staff were not competent to provide care and treatment in line with their roles, the service was unable to demonstrate that it held any previous competency records for nursing staff; leaders told us staff 'self-certificated' their competency.

A lack of assurance on staff competencies was highlighted as a concern in our previous inspection report. Since our last inspection, the trust had developed a new competency database system which was designed to record each required competency for every nursing staff member and the sign-off date. However, the system had been introduced in December 2019. Given the absence of previous competency records, the system could only be populated after individual competencies for each staff member were observed, assessed and signed-off.

Three clinical practice facilitators supported the learning and development needs of staff but also worked clinically. A clinical practice educator told us that work to re-assess staff competency was ongoing. With a divisional staff compliment of 300 people to complete, 84 staff were currently in the process of having their competencies re-assessed. This was supported by the use of the Royal College of Nursing's Emergency Nursing level one and level two competency frameworks.

Managers gave all new staff a full induction tailored to their role before they started work. The clinical practice facilitators had introduced an eight week induction programme for new staff in the adult emergency department. This consisted of two weeks initial training with the facilitators during which staff completed mandatory and role specific training, followed by six weeks of working in the department as supernumerary staff. The supernumerary period could be reduced or extended depending on the experience of each individual.

New staff joining the paediatric emergency department were provided with the initial two week training programme with the clinical practice facilitator, after which further training was provided through the trust's education centre.

Staff had the opportunity to discuss training needs with their line manager. The service had introduced a 'purple shift' to provide additional support, learning and development of competencies. This identified a senior consultant and nurse, identified by a purple uniform, who were available each shift to support the learning needs of other staff.

Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. Paediatric trained staff told us they were not receiving structured supervision. One of the clinical practice educators told us they were not given an induction into that role and, although they have since been able to apply for additional training themselves, it was not always clear if all staff were aware they could access potential external courses through the trust's education centre.

At the time of the inspection, the service had four trainers for the Manchester triage system. An action plan was in place for reassessing any staff that undertaken triage.

Appraisal rates

Managers did not consistently support staff to develop through yearly, constructive appraisals of their work.

From 5th October 2018 to 4th October 2019, 67.1% of staff within urgent and emergency care department at the trust received an appraisal compared to a trust target of 95%. Appraisal completion rates varied throughout the year as a result of different staff start dates, and with any influx of new staff members. Managers told us that nursing appraisal rates in November 2019 were at 80%; however, this has dropped to 69.1% at the time of the inspection because of the number of new staff in the service.

Trust level

Staff group	5th October 2018 to 4th October 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and Ancillary	2	2	100.0%	95%	Yes
Add Prof Scientific and Technic	1	1	100.0%	95%	Yes
Allied Health Professionals	2	2	100.0%	95%	Yes
Administrative and Clerical	25	29	86.2%	95%	No
Nursing and Midwifery Registered	76	112	67.9%	95%	No
Additional Clinical Services	32	56	57.1%	95%	No
Medical and Dental	13	23	56.5%	95%	No
Total	**151**	**225**	**67.1%**	**95%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers recruited and supported volunteers to support patients in the service. We observed a number of volunteers undertaking tea and meal rounds, and staff spoke positively about the impact of one particular volunteer without whom, staff said, the needs of patients waiting in the ambulance corridor would sometimes be unmet.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. In 2019, the service had introduced a frailty intervention team (FIT team) in addition to the functional risk equipment social and home environment team (FRESH team). The FIT team was multidisciplinary with physio and occupational therapy staff, GP and geriatrician staff, social work staff and the 'back home' team while the FRESH team included a range of therapy staff. Both teams worked towards preventing patient admissions to hospital and working towards helping frail and vulnerable patients attending the emergency department to go back home with support.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Mental health assessment of adults was undertaken by the mental health liaison team, which were employed by a local NHS mental health trust. The adult mental health liaison team were based in the trust and, at the time of the inspection, received their referrals through the hospital bleep system.

Mental health assessment of children was carried out by the child and adolescent mental health service, provided through the same local NHS mental health trust.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The imaging department was co-located to the emergency department.

Health Promotion

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

The service had relevant information leaflets and posters promoting healthy lifestyles and support on the unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included, where appropriate, assessment of patients' abilities to carry out daily activities.

Patients attending with symptoms of alcohol or substance misuse could be referred to the trust's alcohol liaison nurse. The service had alcohol and substance misuse pathways in place, and alcohol and substance withdrawal medicines were available for prescription by doctors.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent but did not always record consent in the patient's records. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we asked were able to describe how they would obtain consent, and actions they would take to escalate any concerns surrounding a patient's capacity to consent.

Staff in the department made sure patients consented to treatment based on all the information available. Staff mainly gained verbal consent from patients for their care and treatment in line with legislation and guidance. However, this was not consistently recorded in patient records.

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

Staff in the paediatric department understood Gillick Competence and supported children who wished to make decisions about their treatment.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and clinical staff received and mostly kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training completion rates for nursing staff were close to, but below, the trust target. Training completion rates for medical staff were lower for mental capacity act level one training at 75%; however, this was due to low numbers of staff eligible for the training.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training courses from October 2018 to September 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	73	84	86.9%	90%	No
Deprivation of Liberties	82	95	86.3%	90%	No

In urgent and emergency care the target was not met for the MCA training module for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training courses from October 2018 to September 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deprivation of Liberties	4	4	100.0%	90%	Yes
Mental Capacity Act Level 1	12	16	75.0%	90%	No

In urgent and emergency care the target was not met for the MCA training module for which

medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We reviewed the urgent application forms for deprivation of liberty of four patients (one in the emergency department and three in the clinical decisions unit); all were completed electronically and accurately.

Is the service caring?

Compassionate care

Staff were not always able to support, treat or care for patients with compassion and kindness during periods of heavy demand on the service. There were times when patients' privacy and dignity was not always maintained, and staff were not always able to take account of or meet patients' individual and basic needs.

During periods of high demand, staff were not always able to be discreet with caring for patients. Staff did not always have time to be responsive or to interact with patients and those close to them in a meaningful way. In our interviews with staff, numerous staff told us they were unable to provide the level of care and compassion they would wish to during periods of high demand on the service.

During our first visit, which included a period of very heavy demand on the service, we observed that staff did not always have the time to interact regularly with patients. A number of patients told us they were cold and that no staff members had interacted with them for lengthy periods of time.

On our second visit to the department, we observed up to fifteen examples where patients' privacy and dignity and basic needs were not maintained. We observed one patient walking round the department in a hospital gown, open at the back; we counted seven staff members walking past the patient without taking action to help the patient maintain their privacy.

We observed another patient in the department who was laying across the chairs in the cubical. The patient had vomited on the floor of the cubicle and we saw no evidence that they had been checked by staff for approximately an hour. It was only after our intervention with senior nursing staff that the patient was checked, and the cubicle was cleaned.

We observed patients waiting on trollies and beds located outside other cubicles. We observed patients waiting on all available chairs in the emergency department, including patients who were receiving intravenous fluids. We observed numerous patients waiting on trollies in the ambulance corridor, and this also extended into the link corridor between the 'majors' unit and the clinical decision unit.

One patient told us they had been waiting for more than two hours for pain relief; the patient had used the call bell numerous times, but this had not been answered. A second patient told us they had been waiting for more than two hours to have a cannula inserted to commence their treatment, and that no-one had spoken to them in over two hours to tell them what was happening. A third, palliative care patient, had waited in the waiting room for more than 48 minutes without

being triaged or being brought through to the ‘majors’ unit; navigation staff at reception told us palliative patients were not prioritised.

During our visits, demand on the paediatric emergency department did not appear to be as heavy as in the adult emergency department. However, the design of the department was not conducive to always maintaining the privacy and dignity of children. This was because the area was ‘open-plan’ with no dividing wall between the assessment cubicles and the waiting area. This meant that children in the waiting room could easily hear any noises made by distressed patients who were being assessed.

Staff mostly followed policy to keep patient care and treatment confidential. However, we noted that, in the paediatrics emergency department patients and visitors were able to see the triage computer screen.

Between October 2019 and December 2019, an audit of privacy and dignity assessment in records in the emergency department indicated an average of 89% of records included privacy and dignity assessment.

Information provided by the trust on the quality metrics audit for the clinical decision unit only included data for July and August 2019 relating to privacy and dignity; this indicated that an average of 94% of patients had their privacy and dignity assessed.

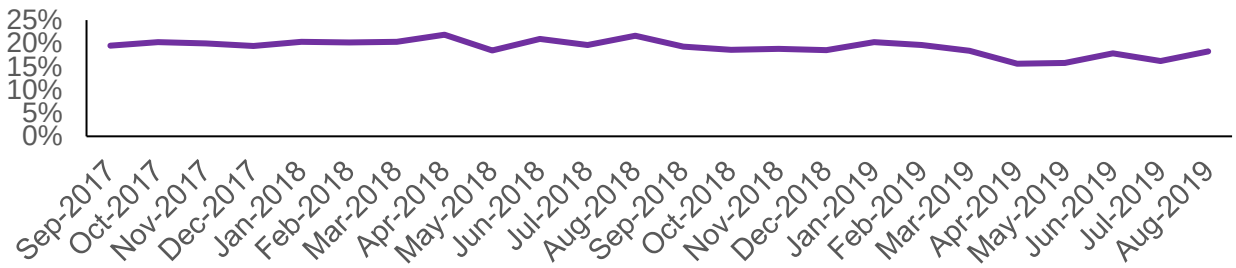
(Source – post inspection additional data request DR3)

Friends and Family test performance

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Friends and Family test response rate

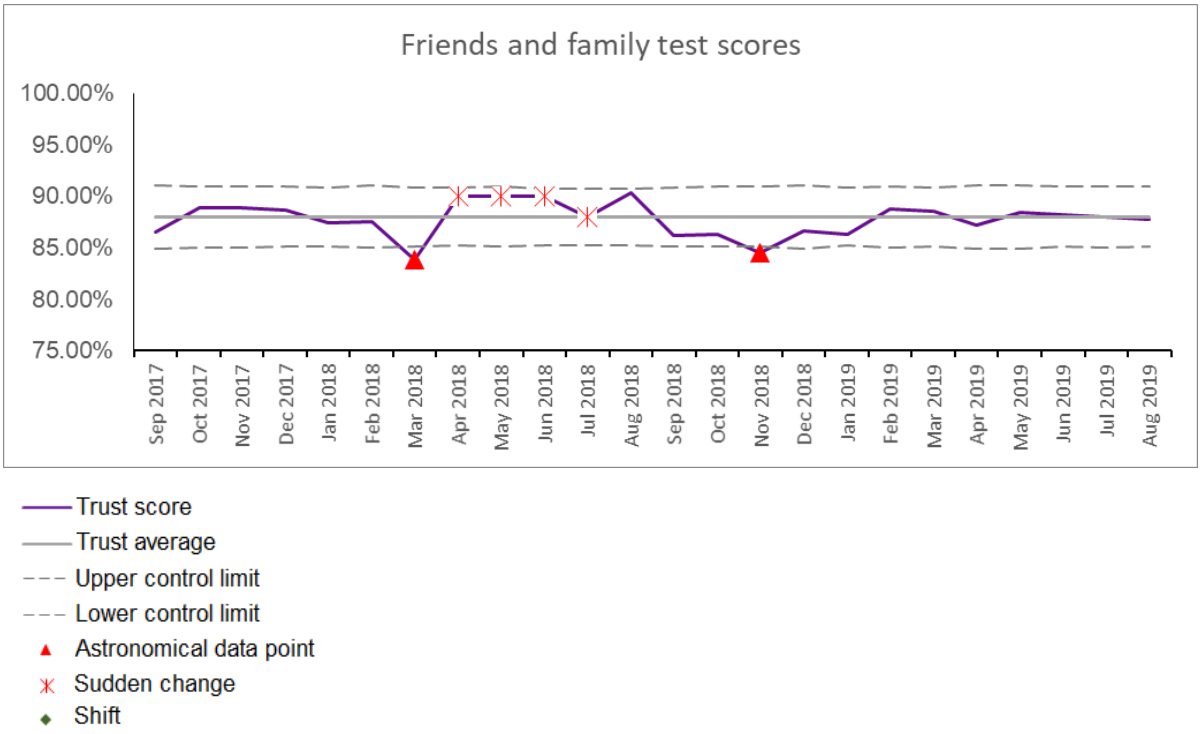
Response rates for the trust from September 2017 to August 2019 are shown below.



The trust’s board papers for February 2020 noted that part of the role of volunteers in the department was to raise patients’ awareness of the Friends and Family Test.

The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 83.8% (March 2018) and 90.3% (August 2018) from September 2017 and August 2019.



(Source: Friends and Family Test – NHS England)

Emotional support

Staff did not consistently see the provision of emotional support to patients, families and carers to minimise their distress as a priority. Staff focused on tasks rather than treating people as individuals and did not always recognise lapses in the maintenance of people's privacy and dignity or give it sufficient priority.

Due to the demands on the service, staff did not always have sufficient time to give patients and those close to them help, emotional support and advice when they needed it. Staff, including doctors and nurses, were focused on their individual tasks and, as such did not always recognise when people needed additional support.

Staff did not always support patients or carers who became distressed in an open environment or help them maintain their privacy and dignity. We saw a critically ill patient, who was living with learning disabilities, in the resuscitation area. The patient was accompanied by a relative who was visibly very upset. We observed long periods when staff did not attend to the patient, and none of the staff noticed or recognised the relative's emotional needs.

We observed, in the resuscitation area, that the curtains had not been drawn around another patient who had very recently died. We saw that a relative of another patient in the area walked past the cubicle and became visibly upset as a result.

We observed a third patient, in the last hours of their life, with active treatment tasks being undertaken without staff talking to the patient or explaining what they were doing. The curtains around the resuscitation cubicle were open, which left the patient exposed.

Our inspection team intervened to provide tissues and some emotional support to another patient in the 'majors' unit who was crying loudly in one of the cubicles as a result of abdominal pain as no staff had responded to the patient. At that point, the patient had been on a trolley in the department for over 15 hours.

From our observations, we were not assured that staff always understood or had sufficient time to provide an appropriate level of support for the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients, families and carers to understand their condition, what was going to happen to them or to make decisions about their care and treatment. During periods of heavy demand, the service did not support a caring environment or approach to people's care, treatment and support.

During our visits, we observed there were differences in staff response to patients' needs between periods high and low staffing numbers comparative to demand on the department at the time. The more 'stretched' staff appeared to be, the more examples of poor care and communication we observed.

This meant that staff did not always or consistently make sure patients and those close to them understood their care and treatment. Further, staff did not always or consistently talk with patients, families and carers in a way they could understand, and we could not be assured that staff always supported patients to make informed decisions about their care.

Our inspection team were asked for help, assistance and information by a number of patients and/or their relatives and carers as they had not been provided with updates by staff. We observed a number of relatives becoming anxious due to the lack of communication by staff. For example, one patient had been told by a doctor they needed an urgent CT (computerised tomography) scan and that it would be carried out within 30 minutes. Our team were approached by the patient's relative after approximately an hour as the patient had not been called for the scan, and nursing staff had not kept the patient updated. We escalated this to staff; however, we were again approached by the relative 30 minutes later as still no staff had been to speak to them to provide an update.

The relative of an elderly patient told us they had received no communication from nurses. This was the patient's second visit to the department in 48 hours and they told us they had received little to no care or communication for ten hours during the first visit. The relative was visibly agitated and the patient was emotionally upset that the same was happening in this second visit.

Patients and their families could give feedback on the service and their treatment and volunteers supported them to do this. Aside from the NHS Friends and Family test survey, the department supported its own patient survey, with information collected by volunteers using electronic tablets. We received feedback data for January 2020. Although the sample size was small 34 out of 40 patients asked said they were given enough time to discuss their care with a healthcare professional.

However, during our visits, patients gave mixed feedback about the service. Although we observed many examples of poor care and communication with patients during our visits, patients were clearly protective of staff. It was not uncommon for patients to tell us that, while they had not been updated or seen by staff in a lengthy time, they recognised staff and the department were extremely busy.

Emergency Department Survey 2018

In the Emergency Department survey 2018, the trust scored about the same as other trusts for each of the 26 Emergency Department Survey questions relevant to the caring domain. It should

be noted that the department had undergone significant change in the environment, staffing, and demand since this survey was undertaken and the results published. As such, it may not reflect the experiences of patients in the current reporting period.

Question	Trust score	RAG
Q10. Were you informed how long you would have to wait to be examined?	4.2	About the same as other trusts
Q11. While you were waiting, were you able to get help from a member of staff to ask a question?	7.4	About the same as other trusts
Q13. Did you have enough time to discuss your condition with the doctor or nurse?	8.4	About the same as other trusts
Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.3	About the same as other trusts
Q15. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.6	About the same as other trusts
Q18. Did doctors or nurses talk to each other about you as if you weren't there?	9.0	About the same as other trusts
Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?	8.1	About the same as other trusts
Q21. While you were in A&E, how much information about your condition or treatment was given to you?	8.6	About the same as other trusts
Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.4	About the same as other trusts
Q24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	8.6	About the same as other trusts
Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.0	About the same as other trusts
Q45. Overall, did you feel you were treated with respect and dignity while you were in A&E?	8.6	About the same as other trusts
Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.3	About the same as other trusts
Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.6	About the same as other trusts
Q28. Before you left A&E, did you get the results of your tests?	8.2	About the same as other trusts
Q29. Did a member of staff explain the results of the tests in a way you could understand?	8.8	About the same as

Question	Trust score	RAG
		other trusts
Q30. If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	6.0	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.5	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.0	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	5.4	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving A&E?	4.5	About the same as other trusts
Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	5.6	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	7.0	About the same as other trusts
Q44. Did staff give you enough information to help you care for your condition at home?	7.0	About the same as other trusts
Q46. Overall	7.8	About the same as other trusts

(Source: Emergency Department Survey 2018)

Is the service responsive?

Service delivery to meet the needs of local people

The service did not consistently plan and provide care in a way that met the needs of local people and the communities served. Although the service worked with others in the wider system and local organisations to plan care; this was not always effective at reducing demand on the service.

Managers did not consistently plan or organise services so they met the changing needs of the local population. Since our last inspection, the trust had expanded the capacity of the department with a new reception area, waiting room with sufficient seating for patients, triage rooms, and an increase in the capacity of the 'majors' area to provide a total of 24 cubicles (of which seven were isolation rooms). The paediatric emergency department had also been redesigned. The service had also undertaken a review of the staffing establishment.

However, despite the expansion, the facilities and premises were not always suitable to meet the demands faced by the service. Leaders in the service acknowledged, and we observed during our visit, the challenges caused by overcrowding in the department and of heavy reliance on bank and agency nursing staff to fill the gaps in the planned nursing establishment.

The service had introduced a GP streaming service operated by its primary care partner providers. A 'navigator' was based alongside the reception team and would stream suitable patients to the

GP triage stream. The role was still embedding and, at the time of inspection, the service was not yet deflecting patients to external GP providers.

Senior leaders told us the department had been designed to accommodate fifty thousand attendances a year, but that the service was expecting the number of attendances to exceed one-hundred thousand in the current year. In the calendar year of January 2019 to December 2019, 100, 520 people had attended the department. There were a number of plans being developed with the aim of reducing demand on the emergency department, including the future development of an urgent care campus. The trust was working with commissioners and the wider healthcare system providers on what the campus would look like and deliver; this was in line with the Greater Manchester plan for all providers to deliver an urgent care centre model.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems. This was through referral to the mental health liaison service provided by a partner NHS mental health trust. Patients presenting with mental health symptoms were placed into the mental health interview room. Staff told us the relative's room was sometimes used for low-risk mental health patients; however, we observed the room contained a number of ligature points and was located at the end of the ambulance corridor.

Patients arriving with head injuries or chest pain were identified and were prioritised to a triage room next to the entrance to the 'majors' unit.

Patients arriving with symptoms of a suspected stroke were directed to the trust's hyper-acute stroke unit. The unit was located in the department but was part of the trust's medical service.

The service had a missing and absconded patient policy and guideline for staff. The policy had been produced in 2016 and validated in 2017 but had been marked for review in November 2018. Staff told us of examples where the policy had worked well. However, we were not assured that staff in the department were always alert to patients leaving the department. We observed one patient who appeared to be agitated leaving the department but the staff member we asked did not know if the patient had been discharged.

The service relieved pressure on other departments when they could treat patients in a day. The frailty intervention team (FIT), identified and pulled appropriate frail patients from the emergency department for assessment with a view to enabling services to be put in place to avoid an admission to hospital.

Meeting people's individual needs

The service mostly took account of patients' individual needs and preferences. When they had time, staff made reasonable adjustments to help patients access services. The service's frailty and functional risk teams coordinated care with other services and providers to avoid hospital admission or to reduce length of stay. However, the design and layout of the service was not always suitable for patients presenting with mental health problems or living with dementia, particularly during periods of high demand.

The service was located on the ground floor, near to the multi-storey car park and was accessible to those living with mobility problems or needed to use a wheelchair.

Staff supported, where possible, patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service also used a 'veterans passport to health and social care', which assisted staff in understanding any specific health requirements for people who had left the armed forces. Although the service had dementia friendly clocks, the

design and layout of the unit did not meet the needs of patients living with dementia, particularly during periods of heavy demand.

Patients were given a choice of food and drink to meet their cultural and religious preferences. However, there were no processes in place for identifying and assisting patients who needed additional help in eating or drinking.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The mental health interview room was stark, with a number of ligature points and, as such, was not suitable for the needs of those who used the room.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. However, patient information leaflets were predominantly in English. Leaflets included contact details for patients to ring to obtain information in their first language.

The trust's frailty intervention team (FIT) and the functional risk equipment social and home environment team (FRESH) worked to meet the needs of frail and vulnerable people. Their aim was to avoid admission to hospital, to assess patients for more suitable places of care, or to work to provide patients with the support and equipment needed to stay at home. Staff told us of one centenarian patient that had been helped to quickly return home from hospital by the intervention of the frailty team.

Emergency Department Survey 2018 – Type One A&E Departments

The trust scored about the same as other trusts for each of the three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	Trust score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.3	About the same as other trusts
Q12. Overall, how long did your visit to A&E last?	6.1	About the same as other trusts
Q22. Were you given enough privacy when being examined or treated?	8.8	About the same as other trusts

(Source: Emergency Department Survey 2018)

Access and flow

People were frequently and consistently unable to access emergency treatment in a timely way and did not receive the right care promptly during periods of heavy demand. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients were consistently not in line with national standards. People experienced unacceptable waits for admission.

The service performed did not consistently meet national targets and performed consistently worse than the England average, and the trust's improvement trajectory targets, for the same metrics. People waited longer from arrival to initial treatment; for a decision to be made to admit, treat or discharge; and people who were admitted to hospital waited longer for an available bed.

We observed significant congestion in the department during both visits with patients on trollies and beds in corridors, and ambulatory patients including some receiving intravenous infusions on seats throughout the department. We observed staff experiencing difficulty in moving patients within the department due to the volume of people waiting.

The trust was aware of the impact of congestion in the department and reasons for this, which included capacity in the wider hospital and the availability of inpatient beds. The service's leaders told us they implemented the trust's escalation or surge policies as required during periods of heavy demand.

The trust had also implemented twice daily Operational Pressures Escalation Levels (OPEL) framework meetings as part of the OPEL escalation process. These had been established when the trust declared OPEL 4 (the highest level of escalation) in January 2020 and they had decided to continue the meetings at lower levels of escalation to support patient flow in the hospital. We attended a meeting during the inspection. This was well-attended by senior leaders from the directorates. There was executive level leadership and actions were identified for named members of the teams.

However, from our observations, we were not assured that these escalation measures were fully effective in improving the experiences of patients within the department. Several members of staff, including leaders, expressed their views that the wider hospital did not always recognise the pressures within the service. One staff member said that, rather than working to increase the available beds, other departments expected the service to have 'elastic walls' to absorb the pressures. The minutes of the operational meeting on 22 January 2020 noted that the service needed "to enforce the rule that if a patient arrives at the department and they are referred to a specialty that specialty needs to accept them".

Leaders told us of a number of initiatives and pilots that had been implemented with a view to reducing congestion in the department. These included the provision of a dedicated frailty assessment area on ward D4, and the provision of additional primary care input to the 'front-door' streaming process. However, these were still embedding, and the results were not expected until the end of February 2020. Other initiatives included medical director-led grand rounds and executive supported whiteboard rounds to identify and drive discharges across the hospital in conjunction with healthcare system partners.

Median time from arrival to treatment (all patients)

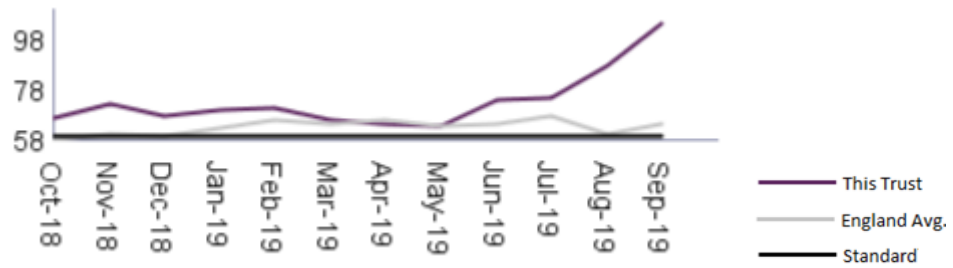
Managers monitored waiting times but did not always make sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in each of the months over the 12 month period from October 2018 to September 2019.

From October 2018 to September 2019 performance against the England average has been worse, with the exception of the period from March to May 2019 where performance was similar.

Over the 12 months, performance has worsened from 67 minutes in October 2018 to 104 minutes in September 2019.

Median time from arrival to treatment from October 2018 to September 2019 at Stockport NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

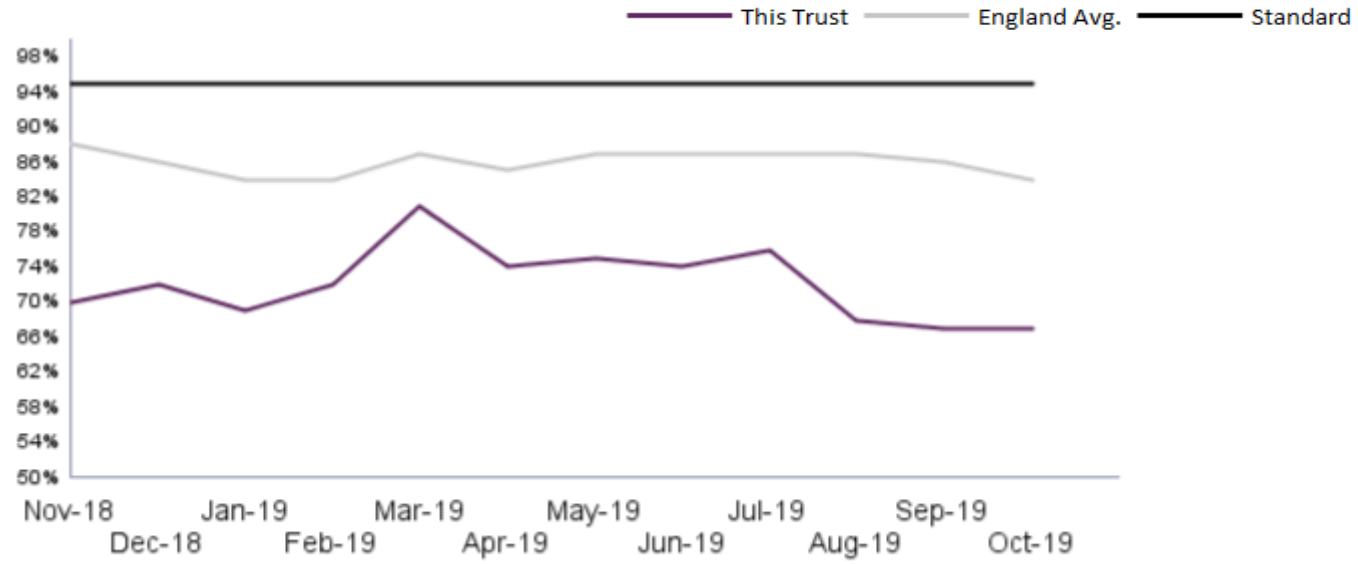
Managers and staff were unable to ensure patients did not stay longer than they needed to.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From November 2018 to October 2019 the trust failed to meet the standard and performed worse than the England average.

In January 2020, the service achieved 64% against this metric, which was much lower than the services agreed improvement trajectory target of greater than or equal to 80%.

Four hour target performance - Stockport NHS Foundation Trust



(Source: NHS England - A&E Waiting times)

Updated data was provided by the trust after our visit. This indicated that, between January 2019 and December 2019, 30,451 patients waited more than four hours to be admitted, transferred or discharged from the service. Of these, 28,064 were adults in the 'majors' unit, 1,507 were adults in the 'minors' unit, and 856 were children in the paediatric unit.

Across the year, as a percentage of all attendances for each of the units, this equated to an average of 50.3% of all patients treated in the 'majors' unit, 6.1% of all patients treated in the 'minors' unit, and 4.3% of all patients treated in the paediatric unit who waited more than four hours.

As a percentage of all type one attendances across all the units, this equated to 60.6% of patients who waited more than four hours.

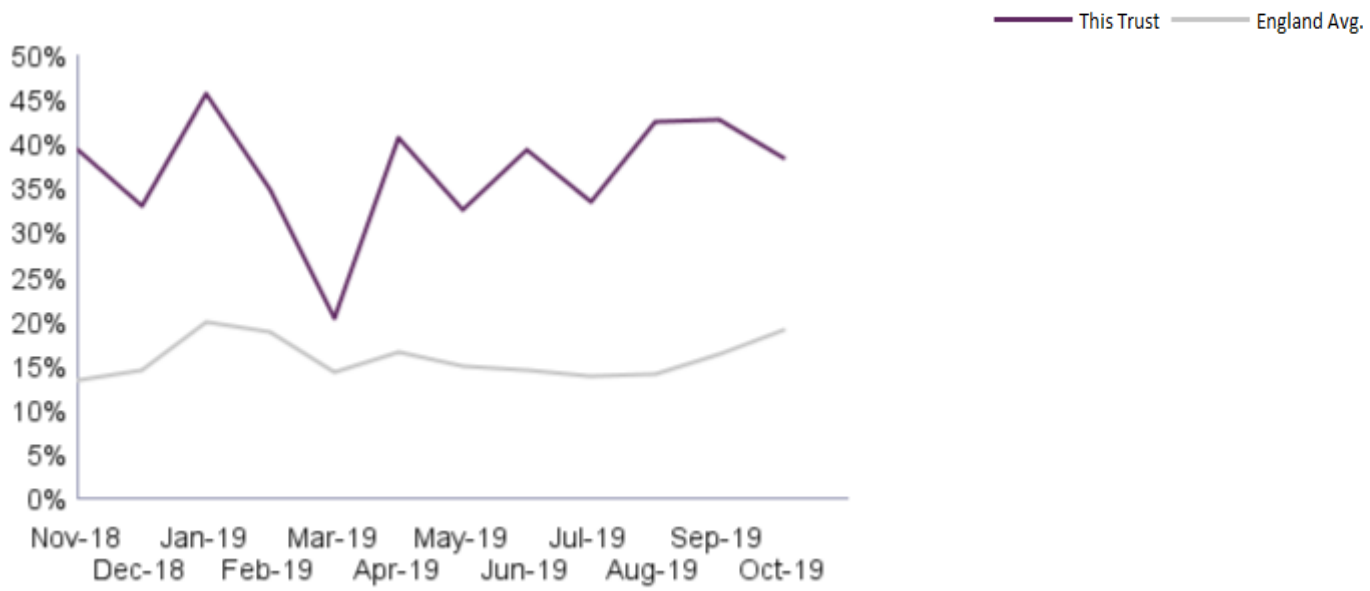
(Source: Post inspection data request – DR1)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From November 2018 to October 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

From November 2018 to October 2019 performance against this metric was variable from month to month.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Stockport NHS Foundation Trust



(Source: NHS England - A&E SitReps).

Updated data was provided by the trust after our visit. This indicated that, between January 2019 and December 2019, there were a total of 29,991 emergency admissions via the emergency department.

During the same period there were 10,948 patients who waited between four and twelve hours for admission after the decision to admit was made. This equates to an average across the year of 36.5% of patients, that had a decision to admit from the emergency department, who waited between four and twelve hours to be admitted.

(Source: Post inspection data request – DR1)

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from September 2018 to August 2019, 164 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in April 2019 (40), August 2019 (22) and October 2018 and June 2019 (18).

(Source: NHS England - A&E Waiting times)

In January 2020, 174 patients waited more than 12 hours for a bed following the decision to admit.

(Source: Trust board papers February 2020)

Updated data was provided by the trust after our visit. This indicated that, between January 2019 and December 2019, there were a total of 29,991 emergency admissions via the emergency department.

During the same period there were 495 patients who waited more than twelve hours for admission after the decision to admit was made. This equates to an average across the year of 1.7% of patients, that had a decision to admit from the emergency department, who waited more than twelve hours to be admitted.

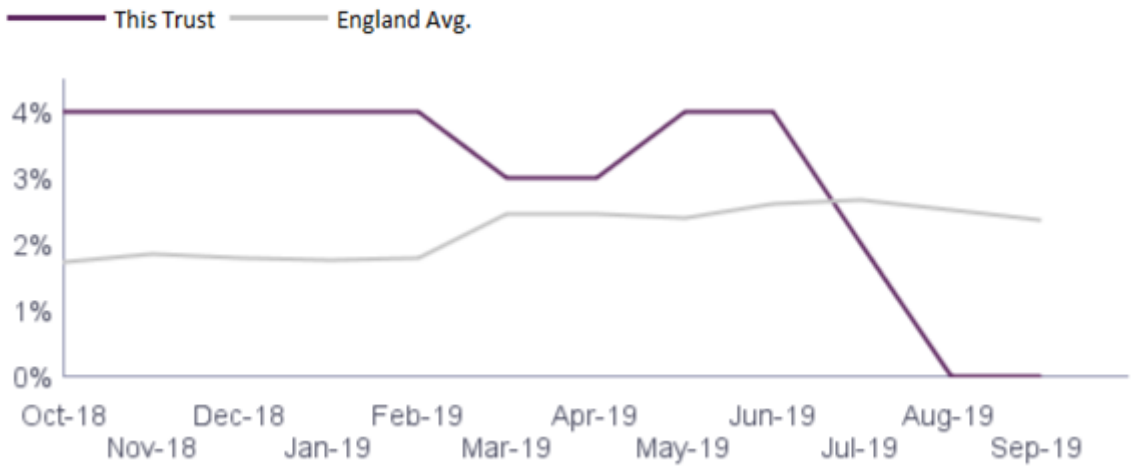
(Source: Post inspection data request – DR1)

We noted that, in line with other organisations, the trust measured the 12-hour period from the point that the decision to admit was confirmed by the receiving speciality. This meant that patients could be in the department for much longer than 12 hours. On our first visit, one elderly patient who had been in the department for approximately 23 hours was not yet classed as having breached the 12-hour target. We saw numerous similar examples during both our visits.

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

The number of patients leaving the service before being seen for treatments was worse than the England average. From October 2018 to June 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was higher than the England average, however performance improved in the most recent months reported.

Percentage of patient that left the trust's urgent and emergency care services without being seen - Stockport NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

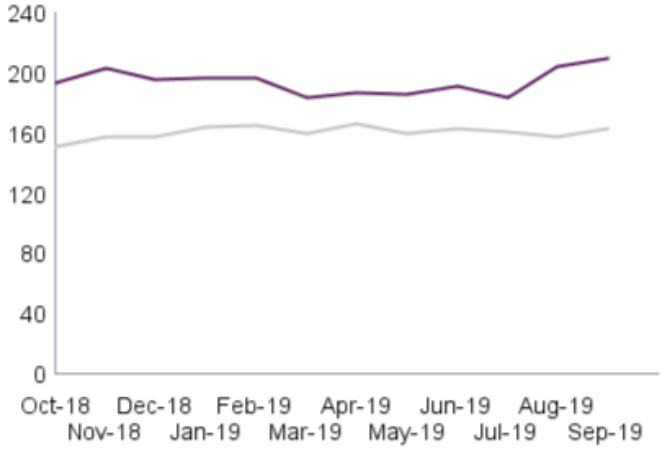
Information proved by the trust after the inspection indicated that the trust's target for the percentage of patients leaving the service without being seen was 5%. In the seven months between July 2019 and January 2020, the trust achieved it's target for five months and exceeded it in November and December when 6.3% of patients left without being seen. However, the service's performance on this measure was consistently worse than the England average.

(Source: Post inspection data request DR164)

Median total time in A&E per patient (all patients)

From October 2018 to September 2019 the trust's monthly median total time in the emergency department for all patients was higher than the England average. From October 2018 to September 2019 performance against this metric was consistently between 180 to 210 minutes and has remained consistent despite the England average showing an increase.

Median total time in A&E per patient - Stockport NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

The service treated formal concerns and complaints seriously and investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. However, it was not always easy for people to raise immediate concerns with staff about their treatment and experiences at the point of care.

The urgent and emergency care service received relatively low numbers of formal complaints compared with the number of patient attendances; 49 between October 2018 and September 2019. It received 112 compliments in the same period.

Patients, relatives and carers knew how to formally complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Leaflets providing information about the trust's complaints process were available throughout the department.

Information about how to complain was also available on the trust's website. It was not prominently displayed, with just a one-line statement and link to the complaints page located within the wider information included on the 'Contact Us' tab.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed five complaints and the trust's responses to them. Four of the five we looked at were responded within the trust's target timescale of 45 working days. The responses to the complaints appropriately identified any failings, poor care or miscommunication, included apologies and clearly set out learning actions taken in a 'how your complaint has made a difference' section.

However, our discussions with patients during our visit indicated that, although some were dissatisfied with elements of their care, communication and waiting times, they were protective of staff and the department. Patients expressed views that they understood how busy staff were and the pressures the department was under.

Staff understood the policy on formal complaints and knew how to handle them. However, from our on-site observations of poor communication by staff, it was not always easy for people to raise immediate concerns with staff about their treatment and experiences at the point of care. Further, we were not assured that staff captured informal complaints or concerns patients had at the point of care. We found no evidence in patient records to indicate that immediate point of care concerns were recognised or captured; for example, concerns such as those expressed to our inspection team by relatives and patients around communication, staff response to requests for help, waiting times, and pain management etcetera.

Managers investigated complaints and identified themes. Managers told us they shared feedback from complaints with staff and learning was used to improve the service during safety huddles and team meetings; for example, following a lost property complaint, a patient property prompt was added to the electronic patient record system. However, several staff we interviewed could not recall being informed of the outcome of any complaints, learning or changes that had resulted from them.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 49 complaints in relation to urgent and emergency care at the trust (11.9% of total complaints received by the trust). The trust took an average of 45.1 days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed within 45 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Other (specify in comments)	29	59.2%
Values & behaviours (staff)	7	14.3%
Waiting times	7	14.3%
Patient Care	2	4.1%
Admin/policies/procedures (inc. patient record)	1	2.0%
Communications	1	2.0%
Admissions and discharges (excluding delayed discharge due to absence of care package)	1	2.0%
Prescribing	1	2.0%
Total	**49**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From September 2018 to September 2019 there were 112 compliments about urgent and emergency care, 8.1% of the total compliments at the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders did not consistently apply the skills and abilities to run the service safely at times of high demand. We were not assured they understood and managed the priorities and issues the service faced well. Leaders were not consistently visible and approachable in the service for patients and staff.

The trust's urgent care services were delivered as part of the division of integrated care services. The division was led by the director of integrated care, associate nurse director, associate medical director, and the assistant director for urgent care.

At department level, and since our last inspection, the service had introduced and was led by a corporate matron and a clinical matron (clinical nurse lead), who oversaw the day to day running

of the emergency departments. However, the high demand on the service and lower than establishment staff numbers, meant that the matrons were not always supernumerary to the staffing numbers. This increased the risk that the effectiveness of their oversight and ability to respond quickly to pressures and changes in the department could be reduced.

We received mixed comments about the visibility of managers and senior staff on the department. While staff had a lot of respect for the clinical nurse lead, more than one staff member commented to us that the senior managers and executives were not often visible in the department.

We were made aware of a letter from the band seven nurses to the senior managers raising their concerns about safety at times of heavy demand. The letter noted that staff felt they were "unable to adhere to [the Nursing and Midwifery Council] code." We also saw the service's response to the letter which acknowledged staff concerns and set out the actions being taken to recruit additional staff, to reduce demand through primary care streaming and frailty assessments, and to support staff to take breaks.

Staff told us they had seen some limited increase in senior leadership visibility in the department as a result of the letter; however, staff questioned why this level of visibility was not routine. After one of our interventions, a staff member commented to us that they had not seen so many managers in the department before, and that recovery from difficult and heavy demand shifts was not usually as quick.

The divisional and departmental managers were able to describe the service's risks and challenges. For example, the overcrowding within the department; staffing and recruitment challenges; and, lack of flow in the hospital. The leaders described the principles of the 'Flow Proposal' 90-day plan, the winter pressures plan and the wider plan for future development of an urgent care campus. However, there was little detail provided on how each of the plans were to be achieved, and we saw no evidence that senior managers had put in place trajectory targets for performance improvement within the department.

Vision and Strategy

There was no service-specific vision, mission statement or guiding values. Winter plans, short-term flow proposal plans, and long term plans for a new urgent care campus were in place and had recently been agreed with local stakeholders in the wider health economy. However, the plans lacked detailed actions, controls, or timescales to evidence realistic objectives or an effective approach to monitoring, measuring, reviewing or progress against delivery of the plans.

The service did not have its own set of vision, values or mission; rather it used the trust's values of "We care, We respect, We listen".

We asked the trust for a copy of its current urgent care strategy. We received a copy of the trust's winter resilience presentation, and a copy of the 'Urgent Care Improvement: Refresh' report for the trust's urgent care delivery board.

The winter resilience presentation demonstrated modelling around the agreed Greater Manchester urgent care improvement plan. This included actions around the themes of 'Stay Well', 'Home First', 'Patient Flow', and 'Discharge' with start and dates ranging from October 2019 through to March 2020. The presentation included elements for the trust such as opening escalation beds, increasing clinical staffing, and increasing staffing for discharge. However, the presentation did not detail specific actions, performance measurables, or target completion dates to achieve these aims.

The ‘Refresh’ report set out a proposal for a renewed structure for the urgent care improvement programme to focus “on key areas of medium to long term improvement and to refocus the weekly operational group on a smaller cohort of key performance indicators to allow for greater grip and to ensure more effective oversight of the weekly operational ‘drumbeat’.” However, it did not specifically set out how measurable performance metrics were expected to improve as a result the new structure.

We also received a copy of the trust’s ‘Flow Proposal’ presentations (also referred to as the 90-day plan) to the Greater Manchester Health and Social Care Partnership and to the trust’s board. The proposal to the board noted “Recent pressures have been so extreme that our efforts have been on maintaining safety at the expense of patient experience.”

The 90-day plan included ambitions to decongest the emergency department through redesign and relocation of the ambulance triage and rapid assessment and treat service to the area occupied by the clinical decision unit; and, the temporary relocation of minor illness and ambulatory ill services outside of the current emergency department footprint that would enable the provision of GP services 24 hours a day seven days a week.

The decongestion plan would run alongside the spot purchase of intermediate care beds to increase available hospital bed capacity in wards and the enhancement and stabilisation of community services. The trust’s aim was to reduce pressure on the service by improving flow in the hospital, by preventing hospital admissions, and by improved early discharge planning.

The board accepted the proposals at the end of January 2020, and we understood from senior managers that the relocation of the ambulance triage and rapid assessment service would be completed within a matter of weeks. However, we were not provided with any specific plans or timescales that would indicate what the expected potential performance improvements as a result of the changes would be, how they would be monitored, or when they would be realised.

Staff were keen to make us aware of the planned development of a new £30.6 million emergency care campus. The campus is planned to include an urgent care treatment centre, GP assessment unit, a planned investigation unit, a new ambulance access road and improvement waiting areas. However, development of the campus was at an early stage, and was subject to planning permission by the local authority, and it was expected to take up to three years to build.

Culture

Staff did not feel respected, supported, valued or appreciated. There were low levels of staff satisfaction, high levels of stress and work overload during periods of high demand. Staff were not always focused on the needs of patients receiving care. However, the service had an open culture where patients and their families could raise concerns without fear.

We spoke with 31 staff during our visits, including managers, doctors, nursing staff and healthcare assistant staff. Almost unanimously, staff we spoke with agreed that when there was ‘flow’ (in-patient beds available to transfer admitted patients to) in the hospital, the department worked well. However, staff expressed concern about patient safety at times of high demand on the service, or during periods of staff shortage. Minutes of the operational meeting on 15 January 2020 noted that “nursing staff feel they get reduced senior nurse support at the weekend”. Staff at all levels described a lack of support from senior managers and expressed their concerns about safety risks to patients cared for on the ambulance corridor due to insufficient staff numbers and lack of suitable equipment.

We observed this during our visits; there was a visible and significant difference in care provided to patients from one day to the next when demand increased, and staffing levels dropped. More than one staff member told us that the high demand we observed during both our visits was 'normal'. It was clear from our observations that pressures on the department directly affected staff's ability to focus the needs of their patients. The 2019 NHS staff survey for the emergency department achieved a lower score (5.5) in the 'safety culture' category than across the division (6.5) or the trust (6.6). In the 'quality of care' category, the department achieved a score of 4.6 against a divisional and trust score of 7.2.

Staff in the paediatric unit told us they did not feel supported by the wider emergency department. They expressed a view that the paediatric department was viewed as being a well-performing unit with experienced staff and, as such, the wider emergency department left staff in paediatrics 'to their own devices'.

Emergency Nurse Practitioners told us they felt "pushed to one side" and were not valued. They told us, in reference to the wider emergency department team, "we are part of the team when they want us to be". Staff felt disengaged by a decision to remove their ability to discharge patients who attended with minor illnesses or injury. Staff explained that all discharges had to be signed-off by a doctor, and this could cause additional delay for patients.

Staff we asked were aware of the principles of the regulatory duty of candour in line with the joint Nursing and Midwifery Council and General Medical Council guidance, Openness and honesty when things go wrong: the professional duty of candour. Staff were able to describe situations where the duty of candour had been applied. Our review of root cause analysis investigation reports confirmed that the duty of candour had been complied with.

The duty of candour is a regulatory duty that requires a health service provider, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body, to notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

We observed a security presence in the department during our out of hours visit. Following changes made to the department, there was no longer a security office within the department. Some staff told us this meant that security staff can now take longer to arrive and that, as such, staff did not always feel protected. The 2019 NHS staff survey for the emergency department achieved a lower score (7.3) in the 'safe environment – violence' category than across the division (9.3) or the trust (9.4).

Governance

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

There was a defined governance structure in place for the service. Staff at all levels understood the structure and lines of accountability within it.

Governance was overseen by the monthly integrated care board, chaired by the divisional director. The monthly urgent care quality assurance meeting, chaired by the assistant medical director had responsibility oversight for, although not limited to, quality, workforce, governance and audit, risks, mortality and morbidity, and performance.

We reviewed the minutes of these meetings and the accompanying key issues reports. While the governance structures mostly operated effectively to escalate known issues, we were not assured that all relevant issues and risks were fully recognised or identify; for example, the lack of use of the safety checklists, the lack of risk assessments of mental health patients, the number of ligature points identified in the department, and the lack of recognition of basic care needs during periods of heavy demand.

The service had an embedded learning from deaths process. All deaths in the emergency department, excluding patients who had pre-hospital cardiac arrests, were reviewed as part of the learning from deaths process. The care of each patient was assessed using a structured case note judgement review process and subsequently characterised as excellent, good, adequate, poor or very poor. Cases with suboptimal care were presented to the quarterly emergency medicine clinical audit and quality forum. This enabled learning from the deaths to be shared.

The learning from death's process required any case review for a patient living with learning disabilities or a child under the age of 18 to be referred to the hospital's clinical governance group to link with the learning disability mortality review programme and the child death review programme as appropriate.

The operational trauma group met quarterly. We reviewed the minutes of the last two meetings in February 2020 and October 2019. The meetings did not appear to have standing agenda items with different topics covered in each meeting, so it was difficult for us to determine the effectiveness of the meetings.

The service held a weekly mental health liaison meeting with the local mental health NHS trust. This included representatives from both trusts along with safeguarding and police representatives. The meeting discussed complex cases and absconders. The working relationship between the two trusts had been set out in a memorandum of understanding.

Management of risk, issues and performance

Leaders and teams were aware of the risks faced by the service and the performance challenges. They identified and escalated relevant risks and issues but did not always identify actions quickly enough to reduce their impact. Plans to cope with unexpected events were not always effective as the approach to service delivery was mostly reactive. Delivery of quality of care was not sustainable during periods of heavy demand or low staff numbers.

The service's leaders described the main risks and challenges to the service with the highest risks focused on overcrowding of the department, nursing and medical staffing shortages. These were reflected on the integrated care business group's risk register. The register included descriptions of each risk, a summary of the current controls, a risk rating and actions to be taken with a target date and target rating score after the actions.

The copy of the register we viewed was provided as part of the pre-inspection information request and included some risks we expected to see. However, it did not include risks we identified, or staff told us about during the inspection all of which are likely to have been present at the time the register was produced. Such risks included paediatric emergency department staffing levels; the availability of reliable vital sign monitoring equipment; risks to mental health patients awaiting assessment by the mental health liaison team; environmental risks such as ligature points in the mental health interview room, family room, and toilets, or the risk of absconding patients

Further, the mitigation actions identified were summarised by single line titles such as “recruitment of international nursing”, “retention of staff”, “please refer to actions of the programme delivery group”, “review SURGE planning”, and “project phoenix”. This meant we were not able to assess the appropriateness, or robustness, of the actions identified.

Leaders were able to describe some of the actions being taken to mitigate the risks. These actions included recruitment of international nurses using video-conferencing to interview potential recruits; the introduction and recruitment of four nurse associate roles; and working with local universities to attract newly qualified staff.

In an attempt to retain staff, the service had recently introduced ‘purple shifts’ where experienced medical, nursing, and clinical practice facilitator staff provided support to junior doctors and staff to build their competencies.

In order to manage demand on the hospital, the service had introduced the FIT team to work with frail patients to avoid admission to hospital and to enable them to return home with relevant support.

In an attempt to improve flow within the department, particularly with ambulance handovers, plans were being put in place to move the ambulance rapid assessment and treatment service to the existing clinical decision unit area to be overseen by a band seven nurse.

However, the impact of the improvement actions had yet to be realised. On both visits we identified significant risks to the delivery of basic patient care and communication as a result of the heavy demand and overcrowding in the department. With a heavy reliance on bank and agency staff, we were not assured sufficient contingency planning of staff numbers was undertaken to mitigate against staff cancellation of shifts. For example, on our second visit which coincided with school half term, the department initially had less than half of the planned nursing staff available at the start of the early shift.

Although leaders told us they had acted in line with the department’s escalation plan on both occasions, the impact of any actions taken did not become evident to the inspection team until after our intervention. One staff member commented to us that the additional support provided was for ‘CQC’s benefit’, and that recovery from overcrowding in the service usually took much longer.

Access and flow performance was monitored throughout the day by a band seven co-ordinator and a dedicated staff member called the tracker using the department’s electronic dashboard. They tracked patients, chased test results, liaised with other departments to escalate bed allocation for patients awaiting admission.

The level of risk and accompanying actions to manage the capacity within the hospital followed the Operational Pressures Escalation Levels framework by NHS England. The framework aimed to align national escalation processes whilst maintaining local quality and patient safety. On our first visit leaders told us the department was working at OPEL 3. This meant the hospital was experiencing major pressures which compromised patient flow.

We observed significant overcrowding in the department on the first day of our inspection, with patients on beds and trollies outside cubicles and in corridors throughout the department. By 9.35pm that day, the department had received 255 new patients, 96 patients were in the department at that time, and the service had 142 breaches of the four-hour target. Staff told us this was ‘normal’. We observed a number of examples of poor care during this period.

During our second visit the department was working at OPEL 2. Although we did not observe significant overcrowding during our second visit, the impact of insufficient staff meant we again saw numerous examples of poor care and communication by staff.

In the previous 12 months, the hospital had declared the highest level, OPEL 4, on two occasions. The hospital had implemented twice daily conference calls with key staff and regional system leaders. In recognition of the continuing pressures on the department, the trust had continued these twice daily calls after the de-escalation to OPEL 3.

We observed, at the time of our second visit, that the service had implemented processes for the management of patients with suspected coronavirus infection. This included an assessment pod (in effect, the decontamination room was used for this purpose), information displayed at reception, and respirator face fit testing for a cohort of staff.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service used a secure electronic patient management and record system. Each staff member had their own log-in ID and password to access the system. An in-built timeout function meant that staff were automatically logged out of the system after a short period of inactivity, which meant that records remained secure.

The management system was linked to a central dashboard that was displayed at the nurses' station. The information provided on the dashboard enabled staff to prioritise the most unwell patients, those at most risk, and to escalate those patients that had been waiting for long periods of time.

The dashboard listed all patients in the department, their location, the responsible doctor and nurse, the patient's presenting symptom, their early warning score, how long they had been in the department, the time they were referred to a speciality and the elapsed time since, their current status, and any relevant alerts (shown as symbols) such as being at risk of falls or living with dementia.

The dashboard also highlighted a range of other metrics, including the number of patients waiting between each hour, up to the four-hour target, the number of patients waiting for beds, the number of patients waiting for a decision on being admitted, and the number of patients suspected of suffering from sepsis.

The service collected and submitted data for all national performance measures and monitored performance in the monthly quality assurance meeting. Daily data for hourly emergency department arrivals and departures, plotted against the number of four hour breaches for those admitted and for those not admitted were available from the trust's patient information system.

Engagement

Leaders and staff engaged with patients and staff; they collaborated with partner organisations to plan and manage services.

The service engaged with patients primarily through the NHS Friends and Family Test survey, and its own internal electronic survey. The percentage of patients that were extremely likely or likely to

recommend the service indicated a downward trend from a high of 88.8% in February 2019 to 82.6% in December 2019.

(Source: Board Papers – February 2020)

The trust's board papers indicated that the chief executive, along with local council and commissioning group partners, had engaged with the local Healthwatch organisation to understand patient experiences and to improve patient engagement in improving flow throughout the service. However, we were not made aware of any other engagement with local partners at divisional or departmental level.

Volunteers used electronic tablets to gather feedback from patients before they left the department. We reviewed the data provided by the trust for the patient feedback survey in January 2020. Compared with the average monthly type one emergency department attendances for the previous 12 months, sample size of 40 (0.5%) was relatively small. The survey focused on a range of factors with questions relating to performance and to their interactions with staff. While patients responded positively to questions relating to their interactions with staff, the responses relating to performance measures reflected long waits. Twelve (30%) patients indicated their visit lasted less than four hours, nine (23%) patients indicated their visit lasted between four and 12 hours, and 17 (42%) patients said their visit lasted longer than 12 hours. The remaining patients had indicated 'not really' in their responses so it was unclear how long these visits lasted.

(Source: Post inspection additional data DR153)

Leaders of the service told us they engaged with staff through a range of staff meetings; however, staff we spoke with told us these were not generally well attended. This was for a combination of factors; for example, maintaining patient care while managing staffing levels meant that staff could not always be released to attend meetings, or would need to attend in their own time (albeit a paid attendance). Low attendance was reflected in the minutes of the band five meeting on 2 January 2020, which was attended by four band five staff members.

(Source: Post inspection additional data request DR163)

An integrated care service business group newsletter provided staff with relevant information and news about the division and the department.

The 2019 NHS staff survey indicated lower levels of staff satisfaction and engagement in the emergency department when compared with the integrated care directorate and the trust as a whole:

	Department Score (out of 10)	Directorate Score (out of 10)	Trust Score (out of 10)
Equality, Diversity and Inclusion	8.7	9.3	9.2
Health and Wellbeing	3.5	5.5	5.6
Immediate Managers	4.7	6.7	6.8
Morale	3.8	6.0	6.0
Quality of Appraisals	4.9	5.8	5.6
Quality of Care	4.6	7.2	7.2
Safe environment – Bullying and Harassment	6.6	8.1	8.1
Safe environment – Violence	7.3	9.3	9.4
Safety Culture	5.5	6.5	6.6
Staff Engagement	5.3	6.8	6.9
Team working	4.7	6.7	6.5

(Source: http://www.nhsstaffsurveyresults.com/wp-content/uploads/2020/02/NHS_staff_survey_2019_RWJ_directorate.pdf)

The trust provided us with a copy of the 2018/19 staff survey action plan. Actions were focused on, although not limited to, promoting health and wellbeing and reducing stress within the division; increasing engagement through staff meetings; extending the period of induction for new staff; introduction of bands five and six development and recognised HR support for training; and, recognising contributions and celebrating success.

Learning, continuous improvement and innovation

Opportunities for staff to learn and improve services were limited. There was inconsistent investment in improvement skills and systems among staff and leaders. Improvements were not always identified, and action was not always taken.

Opportunities to continually improve and innovate were limited by the demands on the service, which reduced the service's ability to release staff for learning and development. Although we noted a range of clinical audits were undertaken to improve services, staff were unable to tell us of any involvement in research projects.

However, the service made regular submissions to the Royal College of Emergency Medicine and the Trauma Audit and Research Network (TARN) which allowed patient outcomes to be benchmarked nationally.

The service had access to a point of care D-Dimer testing machine; the blood test can be used to help rule out the presence of a serious blood clot. This meant that patients attending, or referred to the department, with symptoms of suspected deep vein thrombosis could be streamed into the primary care team for initial testing.

Medical care (including older people's care)

Facts and data about this service

Medical care is provided on the Stepping Hill Hospital site, which is the trust's main acute site, and at its community units. The medical services provided at the hospital include; general medicine, gastroenterology, cardiology, medicine for older people, diabetes & endocrinology, respiratory, stroke medicine, rheumatology, haematology, oncology and rehabilitation. These services are currently provided across 16 inpatient areas including an offsite rehabilitation unit, the Devonshire Unit, and discharge to assess unit, the Bluebell facility. The inpatient areas are supported by multidisciplinary teams including nursing, medical, pharmacy, AHP, health care assistants and social workers amongst others.

As an integrated care trust the medical care team works closely with community teams such as end of life care, enhanced care management team, integrated transfer team and intermediate care services to support care and discharge planning. The medical care team also works in partnership with external organisations such as other provider trusts, commissioners and third sector to support patient care.

The medical care team also provides diagnostic and treatment services which are managed through outpatient and day case or elective stays.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 31,633 medical admissions from July 2018 to June 2019. Emergency admissions accounted for 22,096 (69.9%), 640 (2.0%) were elective, and the remaining 8,897 (28.1%) were day case.

Admissions for the top three medical specialties were:

General medicine – 24,252

Geriatric medicine – 2,571

Clinical haematology – 2,130

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training to all staff but did not always make sure everyone completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for qualified nursing staff in medicine is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Manual Handling - Object	283	288	98.3%	90%	Yes
Infection Prevention (Level 1)	276	288	95.8%	90%	Yes
Fire Safety 3 years	260	288	90.3%	90%	Yes
Basic Life Support	220	249	88.4%	90%	No
Health and Safety (Slips, Trips and Falls)	253	288	87.8%	90%	No
Infection Prevention (Level 2)	233	269	86.6%	90%	No
Medicine management training	224	271	82.7%	90%	No
Information Governance	254	309	82.2%	90%	No
Manual Handling - People	57	207	27.5%	90%	No
Immediate Life Support	42	N/A	N/A	90%	N/A

In medicine the 90% target was met for three of the nine mandatory training modules for which qualified nursing staff were eligible. Immediate life support had no eligible staff but there were 42 members of staff who completed the module.

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for medical staff in medicine is shown below:

Training module name	October 2018 to September 2019				
	Staff	Eligible	Completion	Trust	Met

	trained	staff	rate	target	(Yes/No)
Infection Prevention (Level 1)	73	96	76.0%	90%	No
Fire Safety 3 years	69	96	71.9%	90%	No
Health and Safety (Slips, Trips and Falls)	68	96	70.8%	90%	No
Manual Handling - Object	68	96	70.8%	90%	No
Infection Prevention (Level 2)	52	79	65.8%	90%	No
Medicine management training	50	77	64.9%	90%	No
Information Governance	63	104	60.6%	90%	No
Basic Life Support	13	28	46.4%	90%	No
Immediate Life Support	3	N/A	N/A	90%	N/A

In medicine the 90% target was not met for any of the eight mandatory training modules for which medical staff were eligible. Immediate life support had no eligible staff but there were three members of staff who completed the module.

New staff were given time to complete mandatory training as part of their induction training. This had started six months prior to our inspection. At the time of our inspection mandatory training was under review to identify training according to job role and to meet the needs of patients and staff. For example, identifying which staff would complete training in dementia, learning disability, mental health and acute illness training. Overall compliance for acute illness course for December 2019 was 55.1%. The service had plans for role specific training and improvements for mandatory training compliance.

Manual handling-people and basic life support training sessions were scheduled. Managers monitored mandatory training and alerted staff when they needed to update their training. However, completion of mandatory training was dependant on the staffing levels for the wards and was rearranged when needed. This had not improved since our last inspection.

Safeguarding

Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed the required level of safeguarding training and the service lacked oversight of training levels.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. The trust initially supplied data for safeguarding children level one training. We requested training data for adult and children safeguarding training following our inspection.

Trust level

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for qualified nursing staff in medicine is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	301	313	96.2%	90%	Yes
Safeguarding Adults (Level 2)	260	281	92.5%	90%	Yes

Safeguarding Children (Level 1)	262	288	91.0%	90%	Yes
Safeguarding Children (Level 2)	238	278	85.6%	90%	No
Safeguarding Children (Level 3)	0	4	0.0%	90%	No

In medicine the 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for medical staff in medicine is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 1)	86	110	78.2%	90%	No
Safeguarding Children (Level 1)	74	96	77.1%	90%	No
Safeguarding Adults (Level 2)	58	77	75.3%	90%	No
Safeguarding Children (Level 2)	43	64	67.2%	90%	No
Safeguarding Children (Level 3)	1	15	6.7%	90%	No

In medicine the 90% target was not met for any of the safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with were unclear about the level of children safeguarding they had received. The service provided care and treatment for 16 and 17 year olds when required. However, the service could not provider assurance of how many staff had completed the required level of safeguarding training to meet national guidance in 'Safeguarding children and young people: roles and competencies for health care staff intercollegiate guidance January 2019.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence of this on our inspection. Wards had safeguarding details and flowcharts displayed to prompt staff and staff were supported by their ward managers.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust had a safeguarding policy staff could access through the trust internet. The trust had a safeguarding nurse lead and team to support staff for reporting to the local authority multi-agency safeguarding hub.

Cleanliness, infection control and hygiene

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

Ward areas we visited were clean and had suitable furnishings which were clean and maintained. The service generally performed well for cleanliness.

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

Staff followed infection control principles including the use of personal protective equipment (PPE). Each ward entrance had hand gel facilities with notices displayed to prompt visitors to clean their

hands before entering and leaving the ward. Handwashing facilities and protective personal equipment, such as aprons and gloves were available on all wards we visited.

We saw staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Some side rooms could be used for patients who required isolation to manage infection risk during their admission.

Each ward we visited displayed infection rates for the previous month for clostridium difficile (c. difficile) and methicillin resistant staphylococcus aureus (MRSA).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, the estate was aged and we found some issues.

The general environment across the medical wards was aged and worn. Since our last inspection the medical ward A12 had been demolished and relocated as planned due to the age and condition of the ward environment.

We were told environmental risk assessments had been completed by the estates department for the medical wards. There were a number of actions to be completed to make improvements and this was to be completed through a priority list. An external provider was commissioned to undertake an independent review of the hospital estate condition which considered and evaluated the hospitals physical condition, statutory compliance, functionality, quality and environmental management. It was identified the capital expenditure levels were not sufficient to reduce the identified maintenance backlog significantly.

Staff worked around the old-style nightingale ward challenges of limited space between beds and individual privacy when patients needed to use a commode.

We saw a steam leak in the ceiling space above a store room on ward B4 had resulted in damp with equipment and supplies having to be moved. The hoist was kept in the female toilet and moved out of the room when it was in use. Staff told us this had been reported six weeks ago and the maintenance team would fix the leak ‘sooner or later’. Ward B6 were waiting for a bedpan macerator and dishwasher.

We found the ward layout in a number of wards did not provide clear lines of sight to patients. Staff told us either patients with low acuity were placed in these bay areas or a dedicated nurse or support staff was allocated to the bay area with cover from another nurse during their breaks.

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

Wards had clean utility and sluice areas. Staff disposed of clinical waste safely.

The service had recently refurbished a ward to provide a dementia environment for the geriatric services.

Staff carried out daily safety checks of specialist equipment. We reviewed documentation for three resuscitation trolleys and saw that daily checks were completed and documented. On the wards we visited resuscitation equipment could be accessed quickly when needed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

At our last inspection we found the internal audit to assess staff adherence to the sepsis care bundle on the acute medical unit (AMU) in May 2018 showed the audit criteria was not adhered to and none of the standards were met. Post inspection we requested a sepsis update for training. The data for sepsis screening by the wards was 62% for January 2020.and The acute illness management (AIM) compliance rates for December 2019 were: 73% ward A3, 50% ward A11, 50% ward B4, 45% ward B6, 72% ward C3, 27% ward E1, 67% ward E2, 73% ward E3, 33% ward A1 and 53% ward AMU. The service told us patient outcomes had not been affected. There was an action plan with outstanding actions to be completed by February 2020 to improve the timely completion and assessment of treatment.

Following our last inspection, we requested an update for the British Thoracic Society (BTS) Quality standards for non-invasive ventilation (NIV) in adults (April 2018) action plan. Outstanding actions were due to be completed by March and April 2020. NIV was delivered on the acute medical assessment unit, B4 and C4. We requested the nursing staff rotas for the last two months for ward AMU which identified NIV trained staff on each shift. We were provided with the number of staff on each shift and a list of trained staff. It was not clear from the information provided by the trust if there was trained staff on each shift.

The service had introduced national early warning score 2 (NEWS2) in December 2018 and acute illness course training.

Staff completed risk assessments for each patient on admission for venous thromboembolism (blood clots), pressure ulcers, nutritional needs, moving and handling risks, bed rails risk, risk of falls and infection control risk. The risk assessments were completed on the admission ward and reviewed when needed. We reviewed 27 patient records and saw risk assessments had been completed and actions were identified based on clinical judgement.

Risk assessments for outlier patients were initially completed on the medical wards. Patients were risk assessed as low risk to be suitable for outlier wards. We were told acutely unwell patients were kept on the medical speciality wards where possible.

Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care. Day case procedures such as ascitic drains and blood transfusions were performed on the medical day case unit, so they did not interfere with the flow of patients needing acute diagnosis and treatment for a new problem.

We saw person-centred care plans were in place for a number of medical conditions such as stroke, diabetes, respiratory care, heart failure and geriatric medicine. In the patient records we reviewed, we saw patients had been referred to appropriate specialist teams such as gastroenterology, specialist diabetic nurse, dietitians, physiotherapist and cardiology.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff told us patients were seen in priority of clinical need.

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

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

Staffing

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. There was also a high vacancy and turnover rate.

Trust level

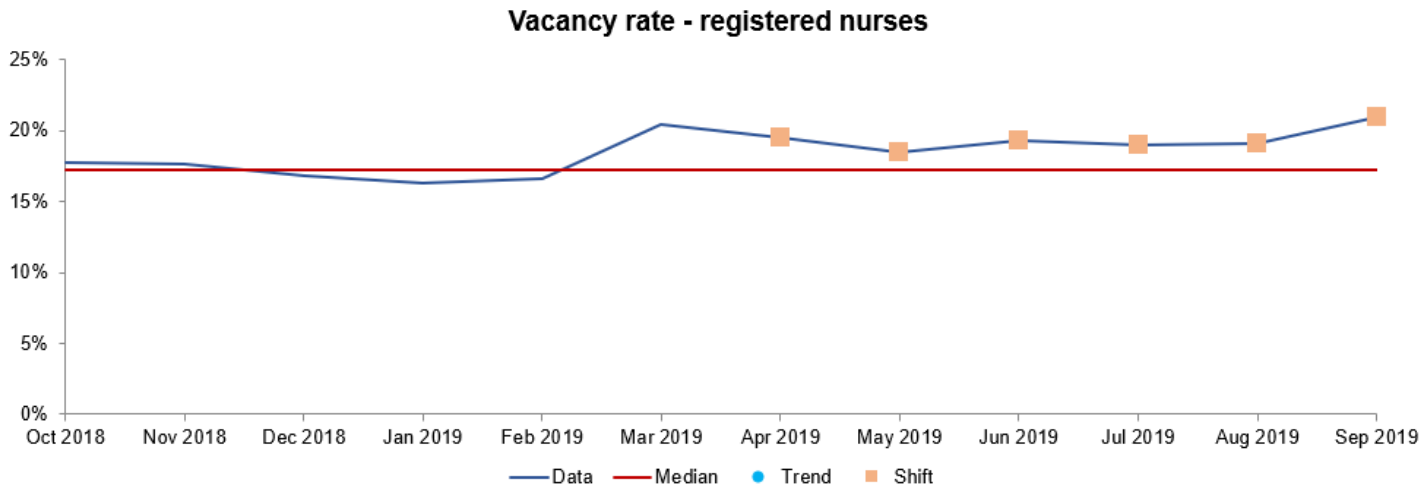
The table below shows a summary of the nursing staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

	Medicine annual staffing metrics						
	October 2018 – September 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	14%	3.5%			
All staff	1,192.2	11%	16%	4.8%			
Qualified nurses	410.2	18%	18%	5.7%	67,909	60,096	N/A

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use and agency use.

Vacancy rates



Monthly vacancy rates over the last 12 months for registered nurses show an upward shift from April 2019 to September 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The service did not use a tool for planning staffing in response to patient acuity and dependency at the time of the inspection. For patients who required one to one support a form was

completed for an additional staff member. Staff told us additional staff were not always provided and they would do the best they could. We saw family members had supported patients by staying with them so there was someone with them. During the period June to December 2019 there was 430 incidents in relation to staffing.

Each ward had the planned number of staff on each shift (early, late and night) with the actual staff number on each shift for the day. All wards we visited had staffing vacancies.

Staffing fill rates for qualified nursing staff below 70% were found as follows:

- B4 65.8%-day shift January 2020.
- A10 65.3%, B4 61.5% and C4 68%-day shift December 2019.
- D4 67%, A10 61.2%, B4 61.2%-day shift October 2019.

We saw evidence that where there was shortfall in qualified nursing staff in these areas, there was an increase in the number of healthcare support workers. For example, there was 162% fill rate against planned levels for healthcare support workers on B4 for day shifts in October 2019.

The service had significant staffing challenges with high vacancy and turnover rates. We were told agency shift booking requests were often handed back to the trust unfilled which created operational challenges with short term sickness and managing patient safety. A scheme to rotate senior nurses on the wards to help with staffing shortages had been introduced.

Staff told us it was not always possible to have additional staff so they would do the best they could and complete an incident report. Following the inspection, we requested the number of incidents logged where one to one care was replaced with intentional rounding. The service told is one to one enhanced care was not replaced with intentional rounding. However, staff had reported insufficient staff to provide one to one care for patients. We were told any staffing deficits were escalated to the matrons or senior nurse out of hours who would visit the ward to review the staffing levels and move staff when possible. The safety of patients would be checked to ensure that care was given as would be expected.

Ward E1 and A11 were identified by the trust as areas of concern for moving staff from the wards to support other wards and high turnover of staff.

Nursing staff from oversees had been recruited but required supervision at the time of the inspection. The trust was undertaking further recruitment of nursing staff to fill the vacancies and had appointed nursing supporting roles to help maintain patient safety.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Medical staffing was supplemented with locum staff. There was also a high vacancy and turnover rate.

Trust level

The table below shows a summary of the medical staffing metrics in medicine at trust level compared to the trust's targets, where applicable:

Medicine annual staffing metrics

	October 2018 – September 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	14%	3.5%			
All staff	1,192.2	11%	16%	4.8%			
Medical staff	127.6	17%	29%	2.2%	34,502 (39%)	33,264 (38%)	20,212 (23%)

Turnover rate for medical staff is almost double what the trust target is.

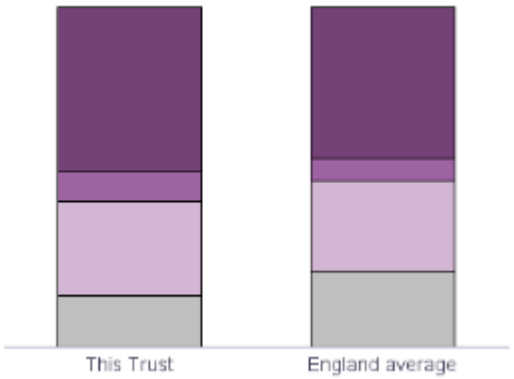
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within medicine were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates.

Staffing skill mix

In July 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 105 whole time equivalent staff working in medicine at Stockport NHS Foundation Trust



	This Trust	England average
Consultant	48%	44%
Middle career^	9%	7%
Registrar group~	28%	27%
Junior*	15%	22%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical (01/07/2019 - 31/07/2019)

The ward and clinical areas we inspected had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients were safe and received the right level of care due to locum and bank staff filling vacant shifts.

There were separate medical rotas in place to cover the specific specialities, such as acute medicine and stroke specialities. Staff rotas were maintained by the existing staff and the use of agency or locum staff. The service always had a consultant on call during evenings and weekends.

The junior medical staff was short of the trust expectations due to the number of assigned deanery placements. We were told talks with the deanery were in progress to secure more junior doctor placements for the future.

There had been an increase of 21 shifts per week to fill with locum and bank staff in January 2020, compared to 19 in December 2020. The chief executive had approved 47 shifts per week in January 2020 to be paid above the medical cap rate of £100 per hour compared to 36 shifts per week for December 2019.

Clinical leads told us the turnover rate was due to medical staff leaving for specialist roles in other hospital trusts.

The service supported the medical vacancies with advanced clinical practitioners, associate nurse practitioner and associate physician roles.

Records

Staff kept detailed records of patients' care and treatment. Although records were clear and easily available to all staff providing care, care plans and risk assessments were not always accurately documented.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 32 patient notes and found five fluid balance charts were not accurately recorded and NEWS2 score above 5 escalation and action taken had not been documented for two patients. This was a documentation error. We saw both patients had been reviewed by clinical staff. We escalated this on inspection to ward managers who told us the service had monthly record audits which looked at these and other areas and identified improvement was needed. Some wards had a nutrition and hydration information board to raise staff awareness and were supported by staff champions.

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

Records were stored securely in locked wall mounted cabinets, trolleys or ward offices. Observational charts were stored securely electronically, and password protected.

The full implementation of an electronic patient record system across the trust had been delayed due to a supply issue. A working group was tasked with the decision to choose another system.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the clinical pharmacy service to outlying patients and escalation wards was not equitable with other medical wards.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

At weekends a pharmacy team completed medicines reconciliations on AMU. Medicines Reconciliation in 24 hours was 73%, broadly in line with the average for non-specialist acute trusts [NHSBSA]. Processes were in place to support safe medicines administration. The trust monitored the timeliness of medicines administration and the number of missed doses. Data showed that unintentional doses omitted was about2% and 90% of medicines were given within 60 minutes of the prescribed time. On admission to the trust, patients who smoked were pro-actively asked about smoking cessation and a range of products could be prescribed to support patients with this.

A weekday clinical pharmacist service was provided to all the medical wards, however there was less regular cover to escalation wards. This meant there was less frequent prescription chart review on these wards. We saw that three patients on these wards (13 records looked at) had missed or delayed administration of antibiotics. One patient had also been given an injection to calm agitated behaviour, there was no up-to-date policy describing the management of violence and aggression and we could not find complete documentation or review of the incident. Similarly, there was no review date on the policy for managing alcohol withdrawal. On another ward we saw one record where thromboprophylaxis had been prescribed contrary to the VTE assessment, the reason for this was unclear.

A safe and secure storage of medicines audit was carried each month. Medical wards performed well with 10 of the 13 wards achieving 100% compliance with audit standards. The remaining 3 wards achieved >90% compliance and an action plan was in place to address any shortfalls [Q3]. The trust had report one incident of missing medication, medication security had been reviewed and the incident was being investigated by the trust. Staff spoken with knew how to report medicines incidents. The National Reporting and Learning System (NRLS) reported medication incident reporting was increasing and now broadly in line with the average for non-specialist acute trusts [2019 NHSBSA to March 2019].

Incidents

Staff recognised incidents and near misses and reported them appropriately. Although managers investigated incidents, learning from incidents was not always shared in the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Never Events

The service had no never events on any wards.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust did not report any never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 35 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from October 2018 to September 2019. A breakdown of incidents by incident type are below.

Incident type	Number of incidents	Percentage of total
Pressure ulcer meeting SI criteria	15	42.9%
Slips/trips/falls meeting SI criteria	10	28.6%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	3	8.6%
Treatment delay meeting SI criteria	3	8.6%
Medication incident meeting SI criteria	1	2.9%
Blood product/ transfusion incident meeting SI criteria	1	2.9%
Surgical/invasive procedure incident meeting SI criteria	1	2.9%
Abuse/alleged abuse of adult patient by staff	1	2.9%
Total	**35**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

All staff we spoke with knew what incidents to report, how to report them and were confident to do so.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported incidents using the trust's electronic incident reporting system. Staff received individual feedback if requested following incident reporting.

Staff told us they would raise an incident regarding any staffing shortages during shifts. Between June and December 2019 there had been 430 staffing incident reports raised for medical wards.

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

Staff met to discuss the feedback and look at improvements to patient care via their safety huddles. There was evidence that changes had been made as a result of feedback.

Managers debriefed and supported staff after any serious incident.

We were told the top six incidents reported for the medical wards were staff workplace stressors, suspected slips/trips/falls, pressure ulcers or skin damage on admission, witnessed falls/slips/trips, pressure ulcer or skin damage on admission or transfer issues. Action and improvement plans were in place to reduce the number of incidents in these areas.

Safety Thermometer

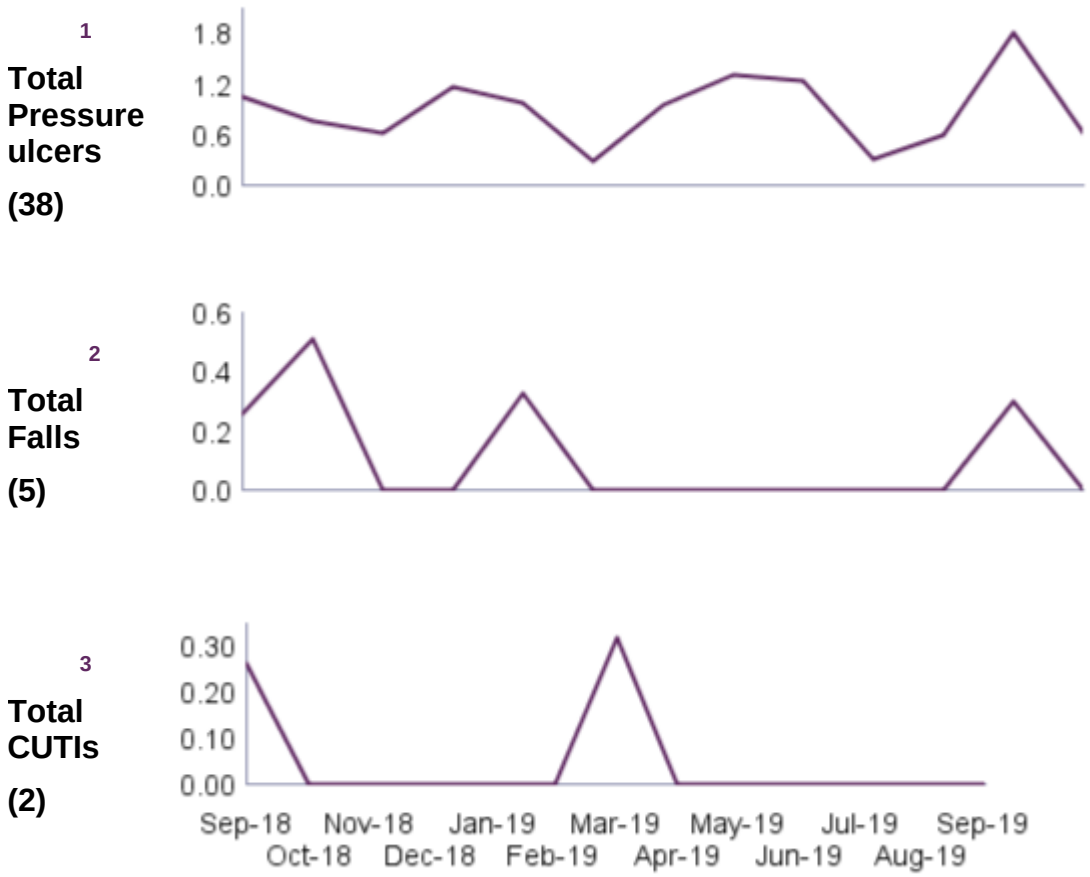
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 38 new pressure ulcers, five falls with harm and two new urinary tract infections in patients with a catheter from September 2018 to September 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at Stockport NHS Foundation Trust



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Safety thermometer data was displayed on the notice boards of the medical wards we inspected

for patients, visitors and staff to see.

Staff used the safety thermometer data to improve services.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

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

Staff had access to current polices and guidance through the trust's intranet. We reviewed four polices during our inspection which were up to date and referenced national guidance.

Clinicians agreed clinical care plans specific to patient's conditions. We were told patient pathways were agreed between clinicians and commissioners for services and this generally worked well. Clinical leads told us they had plans to work more collaboratively with other specialities and have more specialist clinicians for certain disease areas.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

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

However, staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. We reviewed 27 fluid balance charts. The service nutrition audit results for January 2020 overall ward compliance was 69%. Improvement was required for all wards.

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

Pain relief

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

We reviewed 17 patient records and saw pain scores were recorded and reviewed when needed. We spoke with seven patients who told us staff were responsive and were given pain relief when needed. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

The service had a lower than expected risk of readmission for elective care than the England average.

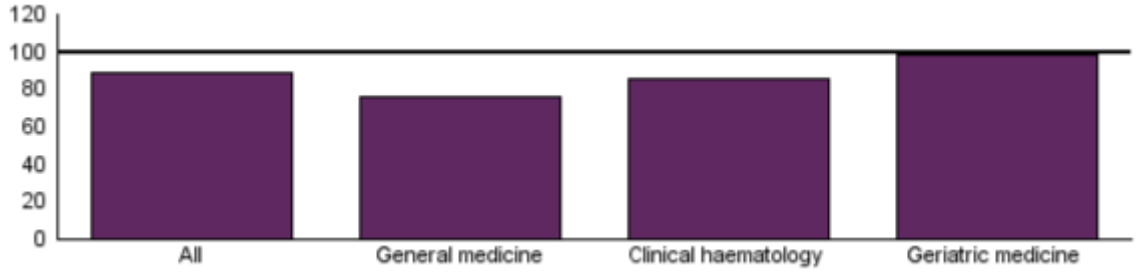
The service had a lower than expected risk of readmission for non-elective care than the England average.

Relative risk of readmission

Trust level

From June 2018 to May 2019, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

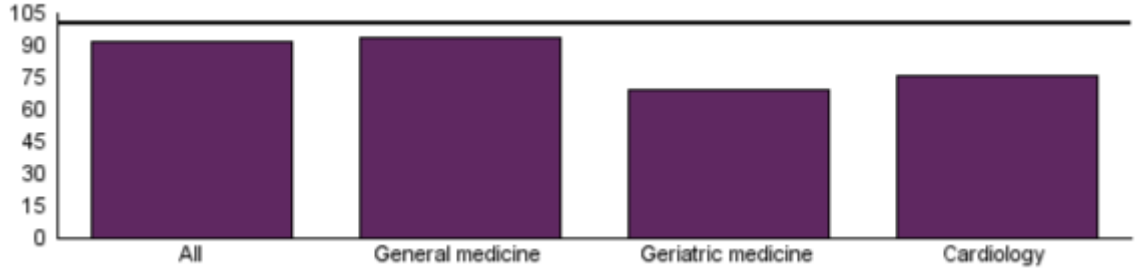
Elective Admissions – Trust Level



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine and clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in geriatric medicine had a similar expected risk of readmission for elective admissions to the England average

Non-Elective Admissions – Trust Level



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine, geriatric medicine and cardiology had a lower than expected risk of readmission for non-elective admissions

(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used audit results to improve patient outcomes.

Managers shared and made sure staff understood information from the audits. Action plans were identified to make improvements. Managers identified areas of risk when the audit objectives were not met.

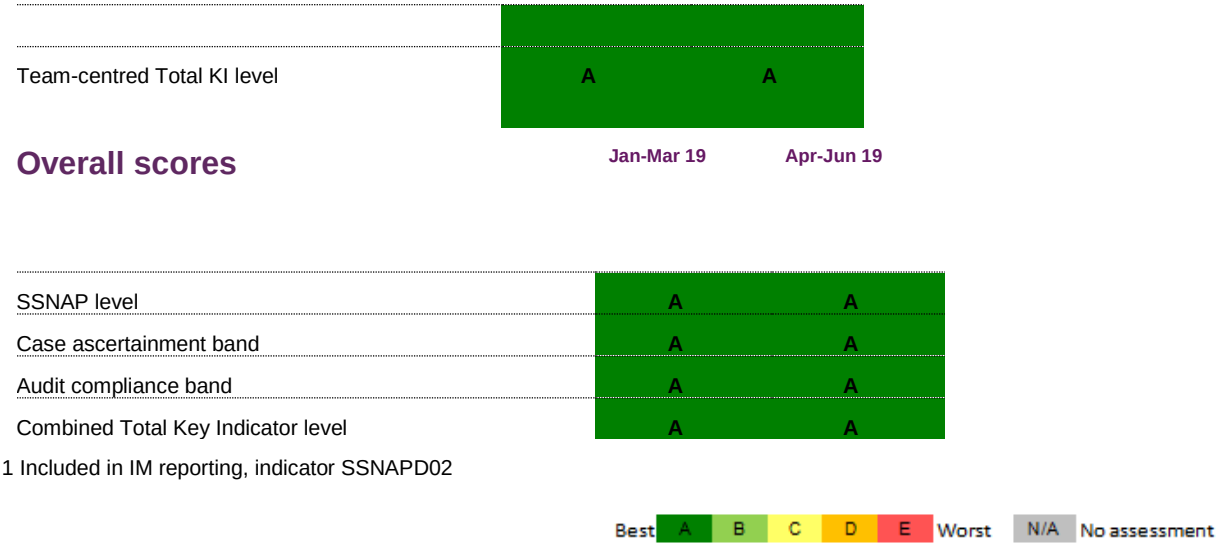
The service was renewing the joint advisory group on gastrointestinal endoscopy (JAG) accreditation at the time of our inspection.

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in latest audit, April to June 2019.

Stepping Hill Hospital

Team-centred KI levels	Jan-Mar 19	Apr-Jun 19
1) Scanning	A	A
2) Stroke unit[1]	B	B
3) Thrombolysis	A	A
4) Specialist Assessments	A	A
5) Occupational therapy	A	A
6) Physiotherapy	A	A
7) Speech and Language therapy	A	A
8) MDT working	B	B
9) Standards by discharge	A	A
10) Discharge processes	A	A
Team-centred SSNAP level (after adjustments)	A	A



(Source: Royal College of Physicians London, SSNAP audit)

At the time of our inspection the service had been rated number one in the country for the SSNAP data.

Lung Cancer Audit

The table below summarises the trust's performance in the 2018 National Lung Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Crude proportion of patients seen by a cancer nurse specialist *(Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)*	79.7%	Does not meet the audit aspirational standard	Did not meet
Case-mix adjusted one-year survival rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	39.1%	Within expected range	No current standard
Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery *(Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen*)	17.0%	Within expected range	Met
Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment	72.1%	Within expected range	Met

(For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)			
Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy *(SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)*	58.2%	Within expected range	Did not meet

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The table below summarises Stepping Hill Hospital's performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national aspirational standard?**
Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?	No	N/A	Did not meet
Crude proportion of patients who had a vision assessment (if applicable) *(Having a vision assessment is indicative of good practice in falls prevention)*	72.4%	Amber	Did not meet
Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) *(Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention*)	38.9%	Red	Did not meet
Crude proportion of patients assessed for the presence or absence of delirium (if applicable) *(Having an assessment for delirium is indicative of good practice in falls prevention)*	56.7%	Amber	Did not meet

Crude proportion of patients with a call bell in reach (if applicable) (*Having a call bell in reach is an important environmental factor that may impact on the risk of falls*)	82.8%	Green	Did not meet

(Source: National Audit of Inpatient Falls)

The service had a trust quality improvement target for 10% reduction in overall falls. The majority of falls in the trust occurred in the medicine and clinical support business group. The service had initiated a falls senor project, introduced new falls risk assessment to include lying and standing blood pressure and monitored staff training. The service also had the National falls CQUIN.

Chronic Obstructive Pulmonary Disease Audit

The table below summarises Stepping Hill Hospital's performance in the 2019 Chronic Obstructive Pulmonary Disease Audit.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Percentage of patients seen by a member of the respiratory team within 24hrs of admission? *(Specialist input improves processes and outcomes for COPD patients)*	17.1%	Worse than the national aggregate	Did not meet
Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%) *(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)*	88.5%	Worse than the national aggregate	Did not meet
Percentage of patients receiving non invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival *(NIV is an evidence-based intervention that halves the mortality if applied early in the admission*)	20.7%	Worse than the national aggregate	Did not meet
Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy *(Smoking cessation is one of the few*	30.4%	Worse than the national aggregate	Did not meet

interventions that can alter the trajectory of COPD)			
Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (*Completion of a discharge bundle improves readmission rates and integration of care*)	25.7%	Worse than the national aggregate	Did not meet
Percentage of patients with spirometry confirming FEV1/FVC ratio <0.7 recorded in case file (*A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt*)	30.9%	Worse than the national aggregate	Did not meet

(Source: Chronic Obstructive Pulmonary Disease Audit)

The service had identified a risk of non-compliance for the recommendations of the national COPD audit in March 2017. There were ongoing actions for this risk which included education of COPD bundle by the respiratory nurse and the audit department to input all paper form information onto the national database. The risk was last reviewed December 2019.

National Audit of Dementia

The table below summarises Stepping Hill Hospital's performance in the 2017 National Audit of Dementia.

Metrics ***(Audit measures)***	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Percentage of carers rating overall care received by the person cared for in hospital as Excellent or Very Good *(A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)*	62.3%	Middle 50% of trusts	No current standard
Percentage of staff responding "always" or "most of the time" to the question "Is your ward/ service able to respond to the needs of people with dementia as they arise?" *(This measure could reflect on staff perception of adequate staffing and/or training available to meet the*	69.2%	Bottom 25% of trusts	No current standard

needs of people with dementia in hospital)			
Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium *(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary*)	52.0%	Middle 50% of trusts	No current standard
Multi-disciplinary team involvement in discussion of discharge *(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)*	85.7%	Middle 50% of trusts	No current standard

(Source: National Audit of Dementia)

The service had appointed a new dementia matron to improve dementia awareness and support within the trust. The matron told us how receptive and supportive the senior leaders had been to identify improvements within the services and work towards changes.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance, but completion rates did not meet the trust target.

Appraisal rates

From October 2018 to September 2019, 79.7% of staff within medicine department at the trust received an appraisal compared to a trust target of 95%. Overall completion for the last financial year was 84.0%.

Trust level

Staff group	October 2018 to September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medical and Dental	73	84	86.9%	95%	No
Allied Health Professionals	75	87	86.2%	95%	No
Nursing and Midwifery Registered	253	316	80.1%	95%	No

Administrative and Clerical	83	104	79.8%	95%	No
Healthcare Scientists	51	65	78.5%	95%	No
Additional Clinical Services	292	380	76.8%	95%	No
Add Prof Scientific and Technic	5	8	62.5%	95%	No
Total	**832**	**1044**	**79.7%**	**95%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The service had paper based records of staff competencies. These were held by different divisions depending on the medical ward speciality. Staff competency was highlighted as a concern at our last inspection. Since our last inspection, in December 2019, the trust had introduced a new competency database system which was designed to record each required competency for every nursing staff member and the sign off date. However, the system could only be populated after individual competencies for each staff member was observed, assessed and signed-off. A new training matrix was in development to support staff training and competency assessment. The service had prioritised which competencies to focus on before completing others. The service could not be assured whether staff were competent at the time of our inspection for all divisions.

Managers gave all new staff a full induction tailored to their role before they started work. The clinical practitioners supported the learning and development needs of staff by introducing an eight-week induction programme for new staff working on the acute medical unit. This consisted of two weeks of clinical training with the training facilitators during which staff completed mandatory training and role specific training, followed by six weeks working on the ward as supernumerary staff. The supernumerary period could be reduced or extended depending on the experience of each individual.

Staff told us training sessions had been cancelled often at short notice, due to ward pressures. In some areas the clinical educators used a purple uniform to go on the ward and work clinically with staff to assess competency. Staff told us it was helpful when the clinical educators came to the ward dressed in purple as they could be assessed while they worked.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

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

Multidisciplinary working

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

Staff held regular and multidisciplinary meetings to discuss patients and improve their care.

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

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants and supporting allied health professionals.

The discharge team worked with staff to support the safe discharge of patients. Staff told us relationships had been strained during levels of high demand and communication was improving to improve patient flow.

Seven-day services

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

Consultants led daily ward rounds on all wards, including at weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Mental health services were provided by a service level agreement with a specialist mental health trust.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included, where appropriate, assessment of patients' ability to carry out daily activities.

Patients attending with symptoms of alcohol or substance misuse could be referred to the trust's alcohol liaison nurse. The service had alcohol and substance misuse pathways in place, and alcohol and substance withdrawal medicines were available for prescription by doctors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and clinical staff received and mostly kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training completion rates were for nursing staff were below the trust target of 90% between October 2018 and September 2019. The training completion rates for medical staff for the same time period were below the trust target for mental capacity act at 74.4% but met the trust target for deprivation of liberty training.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA/DOLS training courses from October 2018 to September 2019 at trust level for qualified nursing staff in medicine is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	238	265	89.8%	90%	No
Deprivation of Liberties	210	241	87.1%	90%	No

In medicine the target was not met for the MCA/DoLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training courses from October 2018 to September 2019 at trust level for medical staff in medicine is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deprivation of Liberties	25	26	96.2%	90%	Yes
Mental Capacity Act Level 1	58	78	74.4%	90%	No

In medicine the target was met for one of MCA/DoLS training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty safeguards in line with approved documentation. We reviewed nine urgent application forms for the Deprivation of Liberty Safeguards and saw they were correctly completed, as well as a capacity assessment. We saw deprivation of liberty care plans and staff assessed patient's capacity daily or weekly depending on the care pathway. Best interest decisions were recorded within the medical notes. This was an improvement from our last inspection visit as patients had not had an ongoing review or assessment of their needs.

There were several local authorities which the trust made applications too, there were no service level agreements with these local authorities, but they had agreed working practices for example, they had agreed they would not make a second application unless there was a material change in the patient's circumstances. All applications were quality checked and forwarded to the relevant local authority on the day of the application by the safeguarding team.

There was a trust electronic patient record system which meant the safeguarding team had an up to date register which identified patients subject to an application and those patients who had been subject of an application previously. The system also identified if a patient was previously subject of an application had been readmitted. When this happened, an email was sent to the ward asking them to consider a capacity assessment. Those patients discharged were automatically removed from the register. There was also a warning symbol displayed on the ward patient display which

identified which patients were subject of an application. Information about which patients were subject of an application was also included on the staff briefing sheet at handovers.

The nine records we looked at were correctly completed with the relevant application forms completed, as well as a capacity assessment. We also saw a deprivation of liberty care plan and staff assessed a patient's capacity daily. There were also best interest decisions made and these were recorded within the written daily notes.

The staff we spoke with were confident they understood their powers and the trust procedures.

Is the service caring?

Compassionate care

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

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

Patients said staff treated them well and with kindness. All patients we spoke with told us staff were wonderful and respectful.

Staff followed policy to keep patient care and treatment confidential.

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

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

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided.

Emotional support

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

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

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

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

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care. The service had a policy and consent form for family members and those close to help deliver some aspects of care.

Is the service responsive?

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of most of the local people and the communities served. It worked with others in the wider system and local organisations to plan care, but this had not always been effective.

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were risk assessed as appropriate for the services being delivered. There was a priority list of actions to improve the fabric of the environment for some wards. There had been improvements to geriatric wards to provide a dementia friendly environment for patients.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems. Support for deafness, learning disabilities, autism and dementia was provided by the safeguarding team. Staff told us patients would be seen as soon as possible depending on the clinical need.

The service had systems to help care for patients in need of additional support or specialist intervention. This included one-to-one patient care for some elderly patients. However, the arrangement for the provision and responsibilities for one-to-one care was documented in draft form awaiting approval and not dated. It was therefore unclear what processes staff were following at the time of inspection.

The service relieved pressure on other departments when they could treat patients on the day without admission. These services were generally provided on the medical assessment day case ward as outpatient appointments.

The leadership teams identified the patient service demographic was elderly and future service planning needed to accommodate their needs and work with community services to deliver care and treatment.

However, the signage throughout the hospital was out of date and included signs for wards that were no longer in use. Staff told us there was a working group to develop new signage for the hospital which would be dementia friendly.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Some wards were designed to meet the needs of patients living with dementia. The dementia matron had introduced a smaller 'This is me' dementia booklet for families to complete. Dementia training and support was offered to carers as well as staff.

Staff used specific care plans when providing care and treatment for patient's living with dementia and stroke patients. We saw evidence these care plans were reviewed and updated when needed.

At our previous inspection we saw a trust-wide 'forget me knot' team of healthcare support workers managed by the medical care services. They carried out one-to-one observations, provided basic care and support for patients living with dementia across the trust. The demand for one-to-one care had increased since our last inspection. Staff completed a request form for additional staff when patients required one-to-one support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

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

Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of obese patients admitted to the medical wards.

Access and flow

There were significant challenges to patient flow within the service. High numbers of medically optimised patients were awaiting transfer or discharge.

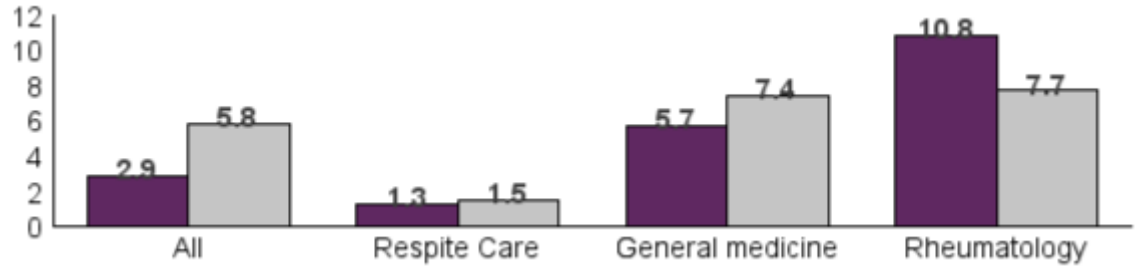
People could not always access the service when they needed it during times of high demand in all medical specialities.

Average length of stay

Stepping Hill Hospital

From July 2018 to June 2019 the average length of stay for medical elective patients at Stepping Hill Hospital was 2.9 days, which is lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.2 days, which is similar to the England average of 6.0 days.

Elective Average Length of Stay - Stepping Hill Hospital

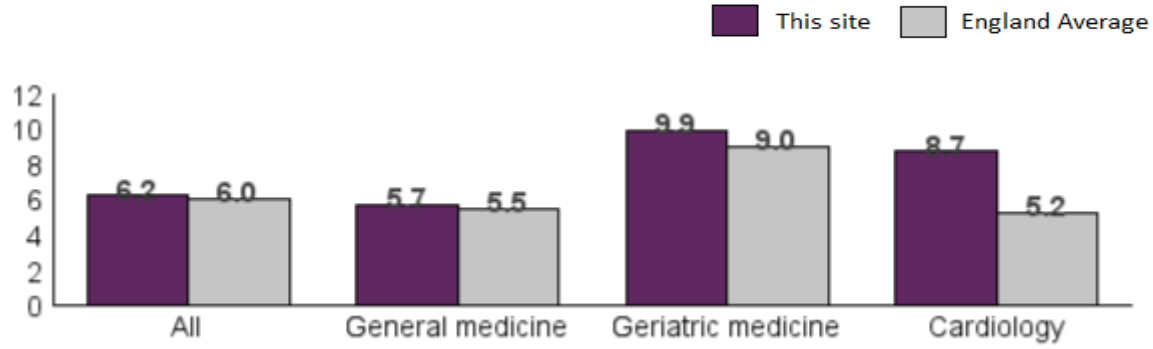


Note: Top three specialties for specific site based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in respite care is similar to the England average.
- Average length of stay for elective patients in general medicine is lower than the England average.
- Average length of stay for elective patients in rheumatology is higher than the England average.

Non-Elective Average Length of Stay - Stepping Hill Hospital



Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is similar to the England average.
- Average length of stay for non-elective patients in geriatric medicine and cardiology is higher than the England average.

(Source: Hospital Episode Statistics)

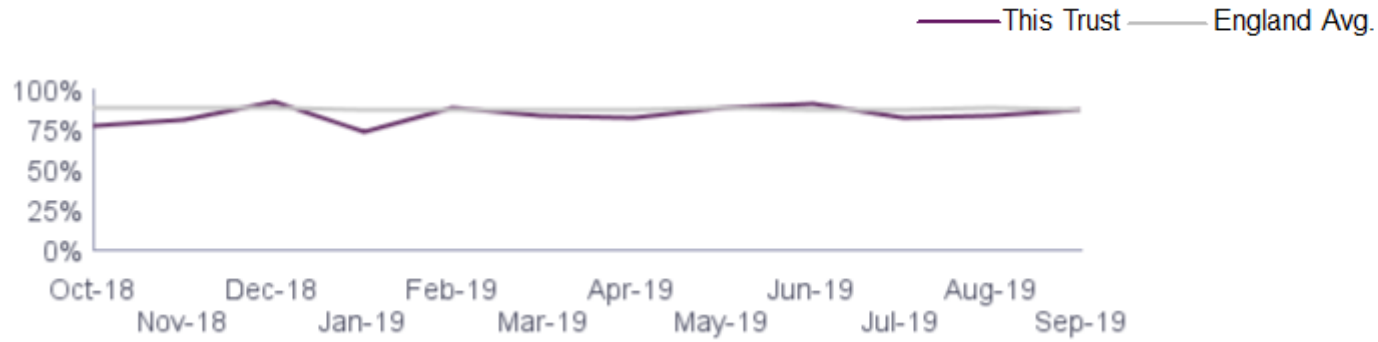
The trust reported the longer length of patient stay for cardiology average length of stay was because there was a pathway in place for patients to go for an angiogram (a type of X-ray used to check the blood vessels) direct from acute medical unit (AMU). Therefore, patients with a shorter length of stay did not routinely progress to a cardiology ward.

The service also had medically fit patients that were awaiting a package of care or long term placement. Work was ongoing to review these patients regularly with social care services to progress the patient's journey. At our last inspection there were four actions the cardiology service had taken to reduce the length of stay from 10.5 days, which had reduced to 8.7 days.

Referral to treatment (percentage within 18 weeks) - admitted performance

From October 2018 to September 2019 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

In the most recent month, September 2019, trust performance was 87.5% and the England average was 87.4%



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Geriatric Medicine	99.0%	96.5%

Two specialties were below the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General Medicine	82.6%	96.3%
Rheumatology	62.0%	94.3%

(Source: NHS England)

Geriatric medicine RTT at our previous inspection was 98.1% and the service had continued to sustain the RTT. However, previously general medicine RTT was 92.7% and rheumatology RTT was 83.9% and we saw the RTT had declined. The service lead acknowledged that if the service worked differently, flow would improve.

Patient moving wards per admission

From August 2018 to September 2019, 98% of individuals did not move wards during their

admission and 2% moved once or more.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

Staff did not move patients between wards at night where possible.

From August 2018 to September 2019, there were 2,992 patient moving wards at night within medicine. 86.1% of these moves occurred on the AMU ward.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers monitored waiting times and made sure patients could access services and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, there were significant challenges to patient flow within the service. High numbers of medically optimised patients were awaiting transfer or discharge. On 29 January 2020, 111 patients were medically optimised. A medical director was leading a multiagency team on a programme of work to reduce days away from home for patients; this was starting to see some results but had not yet had a significant impact.

Due to winter pressures two escalation wards were open at the time of our inspection. These were funded from the winter pressure money and locum medics had been appointed to run the wards.

Managers and staff worked to try and make sure patients did not stay longer than they needed. Discharge planning was estimated on admission and reviewed based on the clinical needs of the patient. Patients told us they were kept informed of delays for discharge. However, the discharge process and funding varied on the area the patient lived. Staff told us discharge was a challenge for complex patients and patients who lived in certain areas. Staff told us this had been escalated to senior managers to help improve the flow from the hospital and mitigate the risk of limited beds due to delayed transfer of care.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. During our inspection we saw two escalation wards had been opened to accommodate the number of delayed discharges. Following our inspection, we returned to the service and found one of the escalation wards had been closed.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Managers worked to minimise the number of medical patients on non-medical wards and had medical outlier criteria-patients who were medically optimised awaiting transfer (MOAT). Post inspection we requested medical outlier information for the last three months. There had been 53 medical outliers in November 2019, 78 for December 2019 and 64 for January 2020. This number did not include the number of patients on escalation wards that were medically optimised awaiting transfer (MOAT). There was a clear process in place for medical outlier patient review. Medical outlier clinical cover changed from November 2018 to simplify the process with one speciality per outlier ward. There had been fewer medical outliers this winter than previous years.

Access to the medical wards through accident and emergency services was dependant on the number of beds available. Senior leaders recognised there was a delay for some medical specialities during high demand and work was ongoing to improve access and reduce the

number of patients who remained on the ward for more than 21 days.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 90 complaints in relation to medicine at the trust (21.8% of total complaints received by the trust). The trust took an average of 53.8 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be completed within 45 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Other (specify in comments)	35	38.9%
Patient Care	18	20.0%
Admissions and discharges (excluding delayed discharge due to absence of care package)	14	15.6%
Communications	14	15.6%
Values & behaviours (staff)	4	4.4%
Prescribing	3	3.3%
Access to treatment or drugs	1	1.1%
Waiting times	1	1.1%
Total	**90**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From September 2018 to September 2019 there were 481 compliments about medicine at the trust, 34.7% of all compliments made to the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service clearly displayed information about how to complain or raise concerns for patients, relatives and staff.

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

We reviewed five recent complaints and saw concerns raised were addressed and improvements identified for learning. For example, consultant of the week was introduced to improve doctor continuity for respiratory medicine.

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

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. Although they understood the issues the service faced, they were not always able to prioritise them or effect positive change. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership of medical wards was spread across three divisions (integrated care services, medical and clinical support services and gastroenterology, surgery and critical care). Each division had an associate nurse director, associate medical director and business group director. Each medical speciality had a clinical lead.

Since our last inspection the service had recruited additional matrons to post. The acute medical assessment ward had shared a matron with the accident and emergency department but now had a dedicated matron. At the time of the inspection there was a ward manager vacancy for the acute medical assessment ward.

Leaders across the divisions did not have a good understanding of staff training, skills and competency of their staff which was identified at our last inspection. Records were paper-based and the information was not held centrally at the time of the inspection. Work was in progress to improve the oversight of staff training, but this was a trust wide project.

Most staff we spoke with told us the leadership team were supportive and visible. The ward managers and matrons were present on the ward and worked clinically when required due to staffing vacancies.

Vision and Strategy

The service did not have clear vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, leaders and staff understood the trust's vision and strategy and knew how to apply this in monitoring progress.

Senior leaders of the service had not identified a strategy for medical ward services. Each medical speciality had development plans for their service. We were told some business cases were in progress and others were in development. Plans included over recruitment to meet with turnover of progression for junior medical staff, additional geriatrician consultants, setting up a frailty service to support the local community, collaboration with the surgical team to optimise patient's recovery, improve flow, reduce respiratory complaints and support medics to specialise into disease areas.

The trust promoted a vision and set of values which were used in communications to the public and members of staff across the trust. The trust's values were 'we care, we respect, we listen'.

Staff we spoke with could readily identify the trust's values and we saw staff routinely demonstrated behaviours which were in accordance with the trust values.

Culture

Most staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were focused on the needs of the patients. Staff spoke positively about the care they delivered. Staff told us it there were pressures due to staff shortages. Leaders expressed praise for staff and were concerned for their wellbeing with the staffing challenges they continued to work through.

Most staff felt confident to raise issues with their line managers and felt managers responded positively when concerns were shared.

At our last inspection, the nursing staff told us that staff moves to support other medical wards with staffing shortfalls had a negative effect on their morale. Since our last inspection staff moves were restricted to within medical speciality to improve staff morale. Staff told us they had seen a reduction in staff moves to other areas and this had helped increase staff morale.

Senior nurses and ward managers told us they had continued to support staff clinically and were not always able to complete their management duties due to staffing constraints.

Staff told us there were cultural differences between some medical specialities and clinicians. Staff said most clinicians were supportive and assisted in learning and development and some were not.

Following the inspection, we requested the latest junior doctor survey result from the deanery. We were provided with the general medical council trainee survey analysis September 2018 report. The action plan for improvements included induction, educational governance, educational supervision, curriculum coverage, adequate supervision, adequate experience, teamwork and reporting systems. Satisfaction rates were 49.5% Rheumatology, 53% cardiology, 59.6% gastroenterology and 84.3% endocrinology/diabetes.

Governance

Although the service had governance structures and processes were followed, there was a lack of robust oversight in key areas. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance was overseen by the three business group triumvirates covering the medical wards. There was a defined governance structure in place for the service. Staff at all levels understood the structure and lines of accountability within it. Each speciality area had routine weekly and monthly governance, operational and clinical group meetings to discuss governance, risk and performance.

We reviewed the meeting minutes for medicine and clinical support business group quality governance board key issues report for January 2020. The report included alerts, assurance, advice and risks which were escalated to board.

We saw there was slow progress for monitoring and actions identified to provide assurance for staff training compliance and competency which was identified at our last inspection.

The medical care services nursing quality care indicators were completed by ward managers or matrons on each ward monthly covering 12 quality care indicators. This included record keeping, NEWS2, medication assessments, pain, infection prevention, tissue viability, nutrition, falls, discharge, fluid balance observation, privacy and dignity.

The Accreditation for Continued Excellence (ACE) ward accreditation tool was embedded since our last inspection. Ward C4 had achieved triple gold. We saw improvement in compliance for some medical wards following our last inspection. As of January 2020, AMU had achieved silver. B6 and C3 were still white wards (lowest rating) and action had been identified to make improvements. The key theme was documentation,

Management of risk, issues and performance

Leaders and teams used systems to identify risks. However, key risks and actions to reduce the impact of risks were not always progressed in a timely manner.

The medical and clinical support services business group risk register documented key risks to the medical care services. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Each risk had a review date and accountable staff member responsible for managing that risk. Risks which scored above 15 were escalated to the trust board.

The oldest risk on the risk register for medical and clinical support services was from November 2016 with a risk score of 16, related to patient safety risk due to registered nursing staff deficient. Although staffing fill rates had improved since our last inspection due to bank staff, there was still a number of registered nursing and medical vacancies that had not been filled. The service was in the process of mitigating the risk of staffing shortages by filling gaps with supporting roles, such as associate nurse practitioners, associate physicians and overseas recruitment, but this had not been completed in a timely manner.

Risks were not always acted on or taken to reduce the risk in a timely manner. For example, actions to improve staff compliance with fluid balance monitoring and the management of patients with sepsis had not improved significantly since our last inspection.

The safe staffing benchmarking review completed June 2019 for occupational therapist and physiotherapist identified shortages. Medical wards were being covered at the weekend with one therapist which was unfunded. It was unclear when the last staffing review had been completed for supporting services. Therapy staff for the in-patient stroke service, medicine for older people and medicine and surgery in total required 8.74 whole time equivalent (WTE) occupational therapists and 6.2 WTE physiotherapists. There was a risk there was insufficient allied health staff to support the stroke and medicine for older people services.

The environment and equipment risks were on the trust risk register. The action plan prioritised what work needed to be completed. The time frame for mitigation was dependant on funding for improvements.

Staff were aware of how to record and escalate key risks onto the risk register.

We saw that routine audit and monitoring of key processed took place to monitor performance against objectives.

Information Management

The service collected data. Data or notifications were submitted to external organisations as required.

Service leaders and managers had access to a range of service data. Leaders reviewed performance data when making decisions about the service.

Computer terminals with intranet and internet access were available throughout the service and there were sufficient numbers of computers for staff to access information and were password protected. Electronic patient records (medicines administration recording system and patient observations) were also password protected. Staff we spoke with did not identify any concerns relating to accessing IT systems or any connectivity issues.

Each ward we visited had quality information boards which provided quality data for staffing levels and safety performance.

There were clear display boards on main corridors and within each ward containing patient feedback for staff, patients and carers to see.

The service submitted audit data and notifications to external organisations when required.

Engagement

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

Staff told us they received good support and regular communication from their line managers. Leaders had continued to use the Schwartz round forum for staff to discuss the emotional and social aspects and challenges of working in healthcare. Staff told us this had been used following the Manchester bombing incident.

Senior nursing staff participated in recruitment events at local universities and with national nursing organisations, to promote the trust and vacancies for potential nurse applicants.

A sepsis week during September 2019 was held and the trust had a sepsis board competition to improve staff awareness and training for patient care.

Learning, continuous improvement and innovation

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

We identified during this inspection that improvements had been made since the last inspection in September 2018. For example, patients restricted under the Deprivation of Liberty Safeguards (DoLS) received an ongoing review and assessment of their needs.

A few matrons had been appointed within the last three months including a dementia matron to support ward managers and staff.

The business group leadership team and local ward leads had a clear understanding of the risks to the services and were aware that further improvements were required to ensure patient safety.

The ward accreditation scheme and nursing quality indicators was helping to drive improvements to ensure patient safety.

The service had recently developed an early support discharge for East Cheshire patients to assist with delayed discharges.

The service had introduced exercise booklets for patients on the ward to promote appropriate activity (‘dressed is best’ and ‘get up moving’).

Maternity

Facts and data about this service

The trust provides midwifery care to 3,100 women and their families per annum throughout the pregnancy continuum within both hospital and community settings.

The hospital-based service based at Stepping Hill consists of an Antenatal Clinic, 18 bedded Delivery Suite including theatre capacity and a recovery area, a combined 28 bedded Antenatal and Postnatal Ward and a co located 3-bed Birth Centre with a 4-bed postnatal area and a Triage / Antenatal Day Unit facility.

The hospital-based service is also supported by an established breastfeeding support service for women within the region.

Community based service offers an integrated Community Midwifery Service that provides antenatal and postnatal care within the community setting and an integrated 24hr homebirth service. In addition to the hospital and community services they also offer a traditional homebirth service and Community Midwifery service to those women living with the High Peak area. This community service is commissioned by Derbyshire CCG and is based at Buxton Hospital. It includes a satellite consultant led antenatal clinic and an ultrasound service.

We inspected the maternity service as part of an unannounced inspection between 28 and 30 January 2020. We visited all clinical maternity areas within the hospital maternity department including the theatre suite. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During the inspection we spoke to over 50 members of the maternity team including midwifery assistants, associate practitioners, student midwives, midwives, midwifery managers, midwifery matrons, the head of midwifery, obstetricians of varying grades, anaesthetists and operating department practitioners and volunteer peer breastfeeding supporters. We spoke with six women using the service.

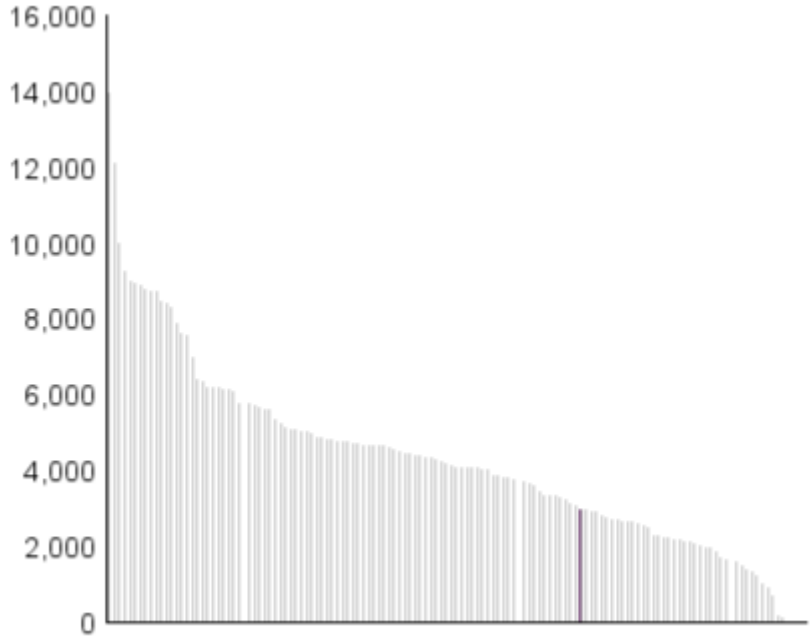
During the inspection we reviewed 15 sets of maternity records and eight prescription records.

(Source: Trust Provider Information Request – Acute sites)

From July 2018 to June 2019 there were 2,963 births at the trust.

A comparison from the number of births at the trust and the national totals during this period is shown below.

Number of births at Stockport NHS Foundation Trust – Comparison with other trusts in England.



(Source: Hospital Episode Statistics (HES))

A profile of all births and gestation periods from January to December 2018 can be seen in the tables below.

Profile of all deliveries (January 2018 to December 2018)			
	STOCKPORT NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	2,990	98.5%	98.6%
Multiple	45	1.5%	1.4%
Mother's age			
Under 20	85	2.8%	3.0%
20-34	2,230	73.5%	74.6%
35-39	620	20.4%	18.5%
40+	100	3.3%	4.0%
Total number of deliveries			
Total	3,035		581,697

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods (January 2018 to December 2018)			
	STOCKPORT NHS FOUNDATION TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	*	*	0.6%
Pre term 24-36 weeks	*	*	7.9%
Term 37-42 weeks	2,810	93.0%	91.4%
Post Term >42 weeks	*	*	0.1%
Total number of deliveries with a valid gestation period recorded			
Total	3,020		472,862

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: This table does not include deliveries where delivery method is 'other', 'Missing' or 'unrecorded'.

Gestation periods were unrecorded for 0.5% of deliveries at this trust compared to 18.7% nationally.

(Source: Hospital Episode Statistics (HES))

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff. However, they did not make sure everyone completed it.

Mandatory training completion rates

Staff were scheduled to receive relevant mandatory training for their roles. However, staff did not always keep up-to-date with their mandatory training. We were told by some staff that one of the reasons for this was that it was not uncommon for staff to be required to work clinically on their planned study days. Following the inspection, we requested data regarding this. In response we were told that staff would be taken off scheduled study days to work clinically due to activity or unexpected staff absences. The department did not monitor or document when this occurred so were unable to supply us with this data.

The trust set a target of 90% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for qualified nursing staff in maternity is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Manual Handling - Object	129	137	94.2%	90%	Yes
Infection Prevention (Level 1)	128	137	93.4%	90%	Yes
Basic Life Support	117	130	90.0%	90%	Yes
Fire Safety 3 years	112	137	81.8%	90%	No
Infection Prevention (Level 2)	107	131	81.7%	90%	No
Health and Safety (Slips, Trips and Falls)	111	137	81.0%	90%	No
Manual Handling - People	56	74	75.7%	90%	No
Medicine management training	78	104	75.0%	90%	No
Information Governance	97	139	69.8%	90%	No

In maternity the 90% target was met for three of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for medical staff in maternity is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection Prevention (Level 2)	10	11	90.9%	90%	Yes
Medicine management training	6	7	85.7%	90%	No
Manual Handling - Object	12	14	85.7%	90%	No
Infection Prevention (Level 1)	11	14	78.6%	90%	No
Fire Safety 3 years	11	14	78.6%	90%	No
Health and Safety (Slips, Trips and Falls)	10	14	71.4%	90%	No
Information Governance	9	15	60.0%	90%	No
Immediate Life Support	1	N/A	N/A	90%	N/A

In maternity the 90% target was met for one of the seven mandatory training modules for which medical staff were eligible. Immediate life support had no eligible staff, but one member of staff completed the module.

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

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

The department facilitated a public health study day which was mandatory for midwives and assistant practitioners to attend and included subjects such as breast feeding. Following the inspection, we requested the up to date compliance rates for these and were supplied the following data:

Midwives	79.9%
Assistant practitioners	85.7%

Safeguarding

Staff that we spoke with understood how to protect women from abuse and the service worked well with other agencies to do so. However, not all staff had completed their mandatory safeguarding training on how to recognise and report abuse. Safeguarding children level 3 training for medical staff had very low compliance rates.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for qualified nursing staff in maternity is shown below:

Training module name	October 2018 to September 2019

	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	129	137	94.2%	90%	Yes
Safeguarding Adults (Level 1)	128	141	90.8%	90%	Yes
Safeguarding Adults (Level 2)	90	101	89.1%	90%	No
Safeguarding Children (Level 3)	107	136	78.7%	90%	No

In maternity the 90% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for medical staff in maternity is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults (Level 2)	7	7	100.0%	90%	Yes
Safeguarding Children (Level 1)	12	14	85.7%	90%	No
Safeguarding Adults (Level 1)	11	14	78.6%	90%	No
Safeguarding Children (Level 3)	2	14	14.3%	90%	No

In maternity the 90% target was not met for the safeguarding training module for which medical staff were eligible.

Medical staff were scheduled to receive training specific for their role on how to recognise and report abuse. However, this group of staff had only met the trust target for compliance in one of the four modules scheduled and the compliance was as low as 14.3% for level three safeguarding training. We requested the services action plan to address and have not received this.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

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

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

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

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

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The department had achieved 100% in the hand hygiene audit for December 2019.

Environment and equipment

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

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

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of women's families.

The service had enough suitable equipment to help them to safely care for women and babies.

All equipment that we observed was in date for servicing and calibration and appeared clean.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women and babies at risk of deterioration. However, although we observed compliance with the World Health Organisations Five Steps to Safer Surgery during the inspection, there was limited evidence that the trust assured themselves this was consistently undertaken.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.

Staff completed risk assessments for each woman on admission / arrival and updated them when necessary and used recognised tools. We reviewed 15 sets of observations during our inspection and observed that they had been escalated appropriately where relevant.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman’s mental health).

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

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

During our inspection we observed an elective caesarean section birth with the woman’s consent. We observed the World Health Organisations Five Steps to Safer Surgery being carried out and completed correctly.

We were supplied with the audit schedule for the World Health Organisations Five Steps to Safer Surgery for both delivery room procedures and maternity theatres which both ran monthly and quarterly from April 2019 to March 2020. There was documented evidence that the audit had been carried out on 10 sets of notes in the delivery room procedures during October 2019 for which they scored 99% compliance. There was no data supplied for the other months. For the maternity theatres audits, there were no documented audits in that time period. It was documented under each month and quarterly section “nil return”. Therefore, it was unclear how

the service were assured they were complying with World Health Organisations Five Steps to Safer Surgery in the maternity theatres.

Midwifery and midwifery support staffing

The service did not have enough maternity staff with the right qualifications, skills and experience. Therefore, we were not assured that all women would be kept safe from avoidable harm and provision of the right care and treatment.

At our last inspection we told the trust that "Midwifery staffing was below establishment meaning that woman's access to maternity care was adversely affected at times. Labour ward co-ordinators were not supernumerary" and they "should continue to work towards staffing the unit to full establishment for the safety of women and babies, to improve access and flow for women and to optimise their choices of place of birth."

At this inspection, we found a nationally recognised maternity staffing tool assessment had last been completed in 2017. Staffing levels were not planned in accordance with this assessment. We reviewed the midwifery staffing business case and executive review from December 2019. This identified that the service required a further 6.7 wte registered midwives in year one and 0.6 wte practice educator in year two. This would enable supernumerary labour coordinators to be in place.

On inspection, we found that the compliance with mandatory training was low, the unit had increasingly closed to women and there was a lack of a supernumerary labour ward co-ordinator on each shift as detailed in national guidance.

We were told that a deep dive had been carried out which highlighted that there were higher risks on night shifts, so they were planning to have two band seven midwives on a night shift first, to ensure the co-ordinator was supernumerary at periods of highest risk. This had not yet commenced.

Within the midwifery staffing business case and executive overview dated December 2019, it was highlighted that phased funding over a two-year period was required to finance staffing and other plans such as estates improvements. This meant that it was planned to take up to two years to ensure all labour ward co-ordinators were supernumerary.

The department manager could adjust staffing levels daily by moving staff to the areas of greatest need or requesting bank staff, according to the needs of women.

Following the inspection we requested the amount of times that community midwifery staff had been called to work in the unit in the past 12 months. We were informed that, on occasion, the community midwives may be asked to work in the birth centre to facilitate 1:1 care and women's choices. However, this was not formally documented.

Trust level

The table below shows a summary of the nursing staffing metrics in maternity at trust level compared to the trust's targets, where applicable:

	Maternity annual staffing metrics
	October 2018 – September 2019

Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual unfilled hours (% of available hours)
Target		10%	14%	3.5%			
All staff	158.5	-5%	10%	3.7%			
Registered midwives	107.2	-9%	8%	4.4%	8,647	108	N/A

Please note that the negative figures for vacancy rates indicate that there were more WTE in post than originally planned.

We are unable to provide a percentage bank/agency usage as the total number of hours available was not provided by the trust. There was also no data provided for unfilled hours.

Nurse staffing rates within maternity were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Midwife to birth ratio

From July 2018 to June 2019, the trust had a ratio of one midwife to every 23.4 births. This was similar to the England average of one midwife to every 24.6 births. However, following the inspection we received updated data within which it was highlighted that between April 2019 and December 2019 inclusive, the trust had an average ratio of one midwife to 29.1 births with a peak in May 2019 of one midwife to 30.2 births.

In the period between April 2019 and December 2019 inclusive, the service had not been able to provide 1:1 care to all labouring women. In this period, it had ranged between 90.2% and 97.8% and was 93.5% for December 2019.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience.

Trust level

The table below shows a summary of the medical staffing metrics in maternity at trust level compared to the trust's targets, where applicable:

	Maternity annual staffing metrics						
	October 2018 – September 2019						
Staff group	**Annual average**	**Annual vacancy**	**Annual turnover**	**Annual sickness**	**Annual bank**	**Annual locum**	**Annual unfilled**

	establishment	rate	rate	rate	hours (% of available hours)	hours (% of available hours)	hours (% of available hours)
Target		10%	14%	3.5%			
All staff	107.2	-5%	10%	3.7%			
Medical staff	14.1	0%	28%	0.1%	3,547 (46%)	3,728 (48%)	433 (6%)

The negative figures for vacancy rate indicate that there were more WTE in post than originally planned.

Medical staffing rates within maternity were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The medical staff matched the planned number.

Managers could access locums when they needed additional medical staff.

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

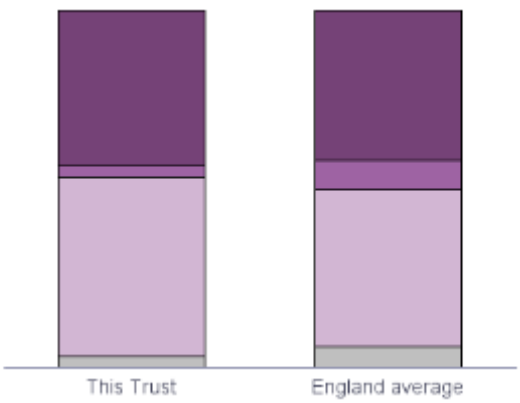
The service had sufficient consultant obstetrician cover for the labour ward that met national recommendations.

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In June 2019, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the 30.6 whole time equivalent staff working in maternity at Stockport NHS Foundation Trust.



	This Trust	England average
Consultant	43%	42%
Middle career^	3%	9%
Registrar group~	50%	43%
Junior*	3%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends.

Records

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

Women's notes were comprehensive and all staff could access them easily.

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

Records were stored securely.

During the inspection we reviewed 15 sets of women's maternity records and found all to be up to date and documented correctly.

Medicines

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

The service utilised an electronic prescribing and recording system. We reviewed eight of these prescription records and found that all were documented appropriately with essential information such as allergies.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines.

Most staff stored and managed medicines and prescribing documents in line with the provider's policy. However, we noted that some community midwives were still carrying glass vials of medicines for home births not in their original manufacturers packaging. This had been highlighted at the last inspection in September 2018. We observed that some midwives carried differing glass vials of medicines, wrapped in cotton gauze and placed in plastic takeaway tubs that they had sourced from their homes. The two staff that we spoke with had reduced the expiry dates in accordance with the manufacturer's instructions and they sourced their medications from the birth centre stock. We were told at this inspection that the pharmacy carrying bags were still on order.

Staff followed current national practice to check women had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed most patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Never events

The service had no never events on any wards.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust reported one never event for maternity. This was categorised a 'Maternity/Obstetric incident meeting SI criteria: mother only' and was a retained foreign object post procedure in October 2018.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported 26 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from October 2018 to September 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Major incident/ emergency preparedness, resilience and response/ suspension of services	21	80.8%
Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	2	7.7%
Blood product/ transfusion incident meeting SI criteria	1	3.8%
Treatment delay meeting SI criteria	1	3.8%
Maternity/Obstetric incident meeting SI criteria: mother only	1	3.8%
Total	**26**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

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

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to women's care.

There was evidence that changes had been made as a result of feedback. For example, we were made aware of the new guideline for women undergoing induction of labour

Managers debriefed and supported staff after any serious incident.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Some safety thermometer data was displayed on wards for staff and women to see.

The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months.

Staff used the safety thermometer data to further improve services.

The service populated a dashboard upon which is highlighted monthly data such as staffing levels, carbon monoxide screening and normal birth rates and the combined operative vaginal birth rates. We observed this dashboard in some senior staff offices which they told us they used to monitor and action results, where necessary.

The trust was one of only eleven in the country identified as an outlier for the 10 standards set by NHS Resolutions which, when complied with, promoted safer care. Following the inspection, we received evidence of their compliance. They told us this had increased from six to eight areas of compliance by providing evidence of a transitional care pathway and that all staff had achieved 90% compliance with mandatory obstetric emergency training. They were aware that staff compliance with this latter maternity safety action was not fully achieved, but told us that they were on a trajectory to achieve 90% by May 2020. The two elements that they were not compliant with were a dedicated caesarean section list staff and supernumerary labour ward co-ordinators.

Is the service effective?

Evidence-based care and treatment

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

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

During our inspection we reviewed 10 of the departments guidelines and found all to be up to date and aligned with national guidance and recommendations.

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

The department were working towards the ambitions set out in “Better Births: Improving outcomes of maternity services in England” and reported that 51 women (20.6%) of women booked in December 2019 were booked onto a continuity of carer pathway.

Nutrition and hydration

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

Staff made sure most women had enough to eat and drink, including those with specialist nutrition and hydration needs.

In the ward area, there was a kitchen where women and their partners were able to prepare and make their own breakfast and drinks throughout the day. Lunchtime and evening meals were served to women at the bedside.

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

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

Specialist support from staff such as dieticians was available for women who needed it.

Pain relief

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

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Women received pain relief soon after requesting it. Women that we spoke with during our inspection told us that they were offered pain relief at appropriate times and felt able to request it at other times.

Staff prescribed, administered and recorded pain relief accurately.

The service used an electronic prescribing system that prevented women from being administered an overdose of pain relief.

Patient outcomes

Staff monitored the effectiveness of some care and treatment. They used the findings to

make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits.

Outcomes for patients were mainly positive, consistent and met expectations, such as national standards.

National Neonatal Audit Programme

The table below summarises Stepping Hill hospital's performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**
Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids? **(***Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity)*	91.4%	Within expected range	Met
Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery? *(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy)*	62.9%	Within expected range	No current standard

(Source: National Neonatal Audit Programme)

National Maternity and Perinatal Audit Programme

The table below summarises Stepping Hill's performance in the 2018 National Maternity and Perinatal Audit Programme against measures related to maternity care.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Meets national standard?**
Trust-level case ascertainment (*Proportion of eligible cases included in the audit)*	103.9%	N/A	Met
Antenatal measures (*before birth, during or relating to pregnancy)*			
Case-mix adjusted proportion of small-for-gestational-age babies (birthweight below 10th centile) who are not delivered before their due date *(Babies who are small for their age at birth are at increased risk of problems before, during and after birth)*	57.1%	Within expected range	No current standard

Intra-partum measures (*during labour and birth)*			
Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (*For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)*	13.8%	Lower than expected	No current standard
Case-mix adjusted overall caesarean section rate for single, term babies (*The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)*	25.1%	Within expected range	No current standard
Case-mix adjusted proportion of single, term infants with a 5-minute Apgar score of less than 7 (*The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)*	1.0%	Within expected range	No current standard
Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (*Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)*	5.2%	Higher than expected	No current standard
Case-mix adjusted proportion of women with severe post partum haemorrhage of greater than or equal to 1500 ml (*Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)*	3.8%	Higher than expected	No current standard
Post-partum measures (*following birth)*			
Proportion of live born babies who	72.2%	Middle 50% of	No current

received breast milk for the first feed and at discharge from the maternity unit *(Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)*		hospitals	standard

(Source: National Maternity and Perinatal Audit Programme)

Standardised Caesarean section rates and modes of delivery

From January 2018 to December 2018 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections as expected.

Standardised caesarean section rate (January 2018 to December 2018)					
Type of caesarean	**England**	**STOCKPORT NHS FOUNDATION TRUST**			
	Caesarean rate	**Caesareans (n)**	**Caesarean rate**	**Standardised Ratio**	**National comparison**
Elective caesareans	12.8%	415	13.6%	104.1	Similar to expected
Emergency caesareans	16.4%	505	16.5%	100.6	Similar to expected
Total caesareans	29.2%	920	30.1%	102.1	Similar to expected

Source: Hospital Episode Statistics, January 2018 to December 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.
This table includes all deliveries, including where the delivery method is 'other' or 'unrecorded'.

In relation to other modes of birth from January 2018 to December 2018 the data below highlights the proportions of births recorded by method in comparison to the England average:

Mode of birth	Births (n)	Births (%)	England average
Caesarean section births 1	920	30.3%	29.3%
Instrumental births 2	395	13%	12.3%
Normal births 3	1,720	56.7%	58.4%
Total births	3,035	100%	100% (n=581,697)

Notes; This data does not include births where birthing method is 'other' or 'unrecorded'.
1 – Includes elective and caesarean section births.
2 – Includes forceps and ventouse births.
3 – Includes non assisted breech and normal births.

(Source: Hospital Episode Statistics (HES)

Maternity active outlier alerts

As of October 2019, the trust had no active maternity outliers.

(Source: Hospital Episode Statistics (HES)

MBRRACE-UK Perinatal Mortality Surveillance Report

The table below summarises the trust's performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2016.

Metrics *(Audit measures)*	Trust performance	Comparison to other trusts with similar service provision	Meets national standard?
Stabilised and risk-adjusted perinatal mortality rate **(***The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK's death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)*	4.69	Up to 10% lower than the average for the comparator group	No current standard

(Source: MBRRACE-UK)

Following the inspection, we requested data of all local audits that the department had carried out in the 12 months immediately preceding our inspection. We received the World Health Organisations Five Steps to Safer Surgery audits; we did not receive any other audits that had been undertaken.

Competent staff

The service made sure that most staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, their appraisal compliance rates did not meet the trust target in any of the staff groups.

Managers gave all new staff a full induction tailored to their role before they started work.

The service employed a cardiotocograph midwife for one day per week to support and train staff in the interpretation of these (Cardiotocography (**CTG**) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy).

The department facilitated Practical Obstetric Multi-Professional Training and cardiotocograph training was included, for maternity staff. Following the inspection, we requested the up to date compliance rates for differing staff groups listed below:

Obstetricians	100%
Midwives	82.9%
Assistant Practitioners	87.5%

Appraisal rates

Managers did not always support staff to develop through yearly, constructive appraisals of their

work.

Trust level

From 5th October 2018 to 4th October 2019, 78.8% of required staff in maternity received an appraisal compared to the trust target of 95%.

Staff group	5th October 2018 to 4th October 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medical and Dental	13	14	92.9%	95%	No
Additional Clinical Services	29	32	90.6%	95%	No
Administrative and Clerical	7	9	77.8%	95%	No
Nursing and Midwifery Registered	111	148	75.0%	95%	No
Total	**160**	**203**	**78.8%**	**95%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had. However, they were not always able to give them the time and opportunity to develop their skills and knowledge.

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

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

Managers recruited, trained and supported volunteers to support women in the service.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care.

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

Staff referred women for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

Key services were mostly available seven days a week to support timely care. However, due to issues with staffing the unit was not always open to women and their families when they wanted or needed them to be.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by midwives and/or consultants, depending on the care pathway.

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

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on every ward/unit such as healthy eating, breast feeding, smoking cessation and pelvic floor exercises.

Staff assessed each woman's health at various points throughout the pregnancy continuum and provided support for any individual needs to live a healthier lifestyle.

We observed notice board in clinical areas highlighting health promotion areas such as delayed cord clamping, skin to skin care and baby led breast feeding initiation within the golden hour.

We observed a notice board which highlighted safer sleeping for babies.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

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

Staff clearly recorded consent in the patients' records.
Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

When women could not give consent, staff made decisions in their best interest, taking into account the woman's wishes, culture and traditions.

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

Mental Capacity Act and Deprivation of Liberty training completion

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

Staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for MCA training modules from October 2018 to September 2019 at trust level for qualified nursing staff in maternity is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	118	130	90.8%	90%	Yes

In maternity the target was met for the MCA training module for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training modules from October 2018 to September 2019 at trust level for medical staff in maternity is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	12	13	92.3%	90%	Yes

In maternity the target was met for the MCA training module for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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

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

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.
Staff implemented Deprivation of Liberty safeguards in line with approved documentation.

Is the service caring?

Compassionate care

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

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

Women said staff treated them well and with kindness.

Staff followed policy to keep women's care and treatment confidential.

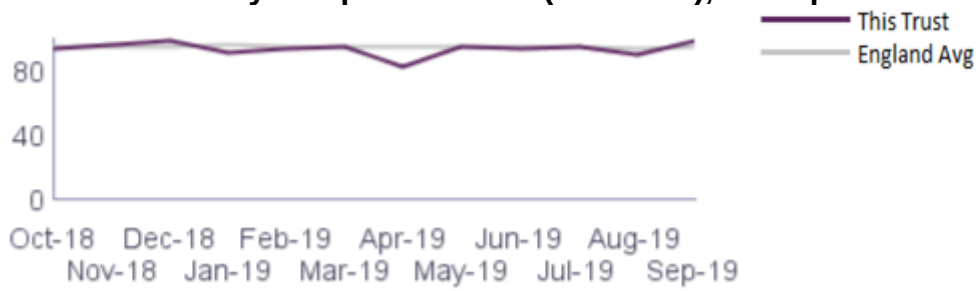
Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

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

Women that we spoke with told us that staff had been helpful and caring throughout their respective stays.

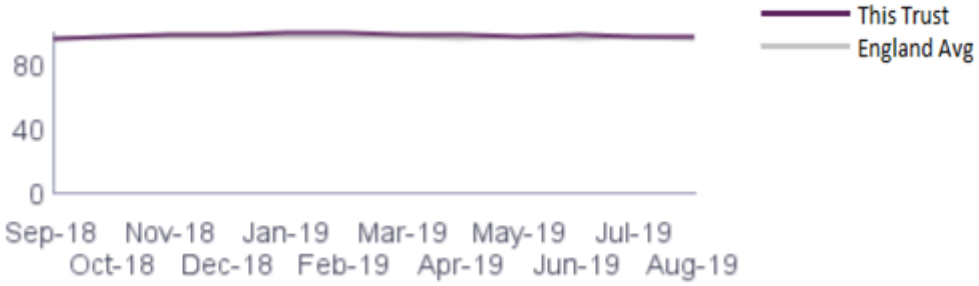
Friends and Family test performance

Friends and family test performance (antenatal), Stockport NHS Foundation Trust



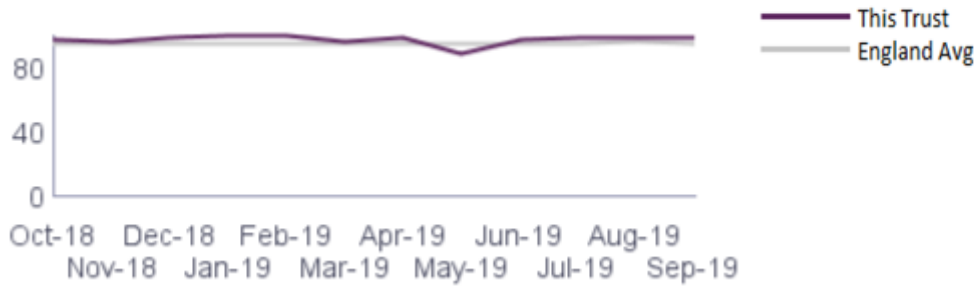
From October 2018 to September 2019 the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

Friends and family test performance (birth), Stockport NHS Foundation Trust



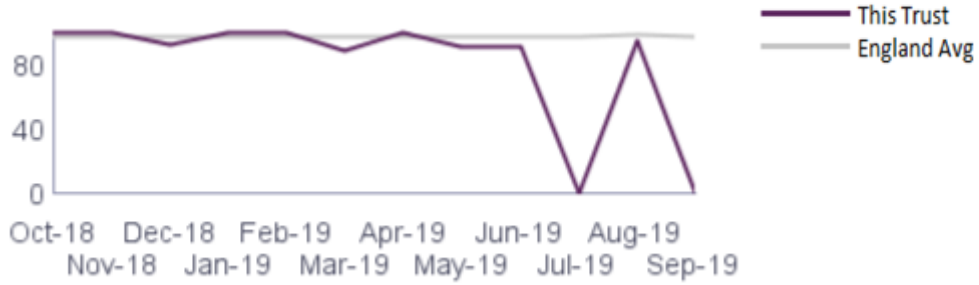
From September 2018 to August 2019 the trust's maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Friends and family test performance (postnatal ward), Stockport NHS Foundation Trust



From October 2018 to September 2019 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

Friends and family test performance (postnatal community), Stockport NHS Foundation Trust



From October 2018 to September 2019 the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In July and September 2019 there were insufficient responses to produce a recommendation rate.

(Source: Friends and Family Test – NHS England)

CQC Survey of women's experiences of maternity services 2018

Area	Question	Score (0-10)	RAG
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.7	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	7.6	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.2	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.6	About the same
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.6	About the same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.8	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.3	About the same
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time	9.1	About the same

	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.3	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	9.1	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.3	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.1	About the same
Care in hospital after the birth	Looking back, was there a delay in being discharged from hospital?	6.4	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	7.4	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	7.6	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.4	About the same
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	8.8	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.1	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2018)

Emotional support

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

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

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

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

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

Understanding and involvement of women and those close to them

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

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

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

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

Staff supported women to make advanced decisions about their care.

Staff supported women to make informed decisions about their care.

The feedback from the Friends and Family Test was positive for all clinical areas.

The department performed similarly to other maternity departments for all 19 questions in the CQC maternity survey 2019.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned care in a way to meet the needs of local people and the communities served for most of the time. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered.

Staff working within the department shared a common goal of providing women centred care. Facilities were available to offer women home births, in the birth centre or in the consultant-led unit. However, the three choices of place of birth for women using this service was not always available and, at times, women were not able to access the service at all.

The service was working towards improving continuity of carer rates in line with Better Births (2016).

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

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

The service employed specialist midwives for conditions such as mental health and diabetes.

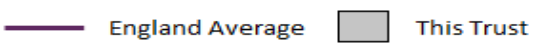
Managers monitored and took action to minimise missed appointments.

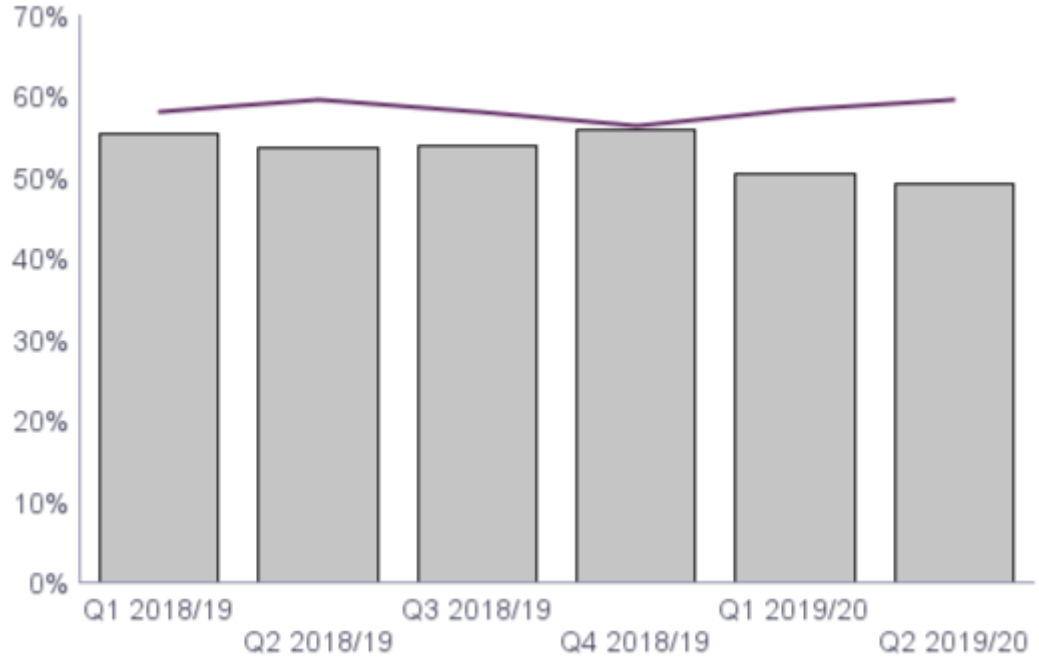
Managers ensured that women who did not attend appointments were contacted.

Bed Occupancy

From April 2018 to September 2019 the bed occupancy levels for maternity were generally lower than the England average, with the trust having 49.0% occupancy in Quarter Q2 19/20 compared to the England average of 59.7%.

The chart below shows the occupancy levels compared to the England average over the period.





(Source: NHS England)

Meeting people's individual needs

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

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

There was a system in place whereby staff could access a translation service to assist them in caring for women for whom English was not their first language.

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

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

Access and flow

People could not always access the service when they needed it to receive the right care promptly.

Between January 2019 and December 2019 inclusive the service closed the unit to admissions on 25 separate occasions for a total of 165 hours and 42 minutes. During these periods 49 woman who had booked for maternity care at this service were diverted to receive their maternity care from neighbouring maternity units. The closures had increased for the last three years from four in 2017, 14 in 2018 to 25 in 2019. Therefore, we were not assured that the trust were managing access and flow adequately.
We were told that due to staffing and acuity issues the birth centre had been closed on occasions and some staff told us that this was almost a weekly occurrence. The senior leadership team told

us during our inspection that this was incident reported only if there was a woman in the unit who was eligible to use this birthing location.

Following the inspection, we requested the number of times that the birth centre closed to admissions. We were told that the birth centre only closed to admissions when the whole maternity department closed. However, we were also told that "There may be times when staff are redeployed to other areas, but the birth centre will not close".

Managers and staff worked to make sure women did not stay longer than they needed to.

Managers monitored that moves between wards/services were kept to a minimum.

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

Staff supported women and babies when they were referred or transferred between services.

Managers monitored transfers and followed national standards.

Learning from complaints and concerns

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

Summary of complaints

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

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

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

Managers investigated complaints and identified themes.

Trust level

From October 2018 to September 2019 the trust received 21 complaints in relation to maternity at the trust (5.1% of total complaints received by the trust). The trust took an average of 45.9 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 45 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Other (specify in comments)	13	61.9%
Values & behaviours (staff)	4	19.0%
Communications	2	9.5%
Patient Care	2	9.5%
Total	**21**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

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

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

service.

Number of compliments made to the trust

From September 2018 to September 2019 there were 88 compliments received for maternity, 6.3% of the total compliments at the trust. The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed most of the priorities and issues the service faced. However, some staff felt the senior leaders were not as visible as they would have liked.

The service had a head of midwifery who was supported in her leadership role by two midwifery matrons and band seven midwifery leaders.

There was a 24 hour per day, seven days per week manager on call that all maternity staff could access at any time.

The head of midwifery was supported in her role by an interim midwifery matron and band seven lead midwives in all relevant clinical areas and specialisms.

Midwives, student midwives and midwifery support workers that we spoke with told us that the midwifery leadership in the unit was supportive and approachable.

Junior doctors and medical students told us that the consultant obstetricians were supportive in their learning and approachable.

Vision and Strategy

The service did not have a formal documented vision and strategy for what it wanted to achieve. However, they were able to articulate some plans of where they wanted the service to be in the future.

The senior leadership team had a vision to make the service more sustainable by increasing the women who choose to birth their baby at the department.

We observed the business case which focused on increasing the women who choose to birth their baby at the trust and was aligned to local plans within the wider health economy.

The service told us of plans to refurbish parts of the maternity unit, such as the birth centre, that were placed on hold, until the outcome of wider strategic planning was decided.

The service was working towards achieving the recommendations highlighted in Better Births (2016) which included continuity of carer and multi-disciplinary working.

Culture

Staff that we spoke with told us they felt respected, supported and valued. They were focused on the needs of women and babies receiving care. The service had an open culture where women, their families and staff could raise concerns without fear.

Student midwives, newly qualified midwives and medical students said they were accepted as an inclusive part of the team from the outset and were made to feel welcome and valued.

All staff that we spoke with told us they would recommend this maternity unit as a place to work.

We saw evidence of, and observed, good working between midwives and obstetricians and all other maternity staff.

Midwives and other maternity staff changed shifts and worked extra hours to help the team out in providing the best care possible to women.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance lead within the service worked hard to ensure that staff reported incidents and received feedback and all staff learnt from incidents.

Copies of guidelines and policies were available to all staff via the trust intranet. Most were up to date.

We reviewed the minutes from the last three quality governance board women's, children's and diagnostics business group monthly meetings of which the maternity service is a part of within the trust. All were well attended by representatives from the maternity service and the agenda included pertinent subjects.

However, following our last inspection, we highlighted that the method that the community midwives used to transport medications to home births would neither prevent the possibility of breakage in transit or the wrong medication being used in an emergency. Whilst we observed evidence that the department had been discussing these issues, they had not been addressed at the time of this inspection.

There was a governance board in the offices informing staff of pertinent issues and achievements in the department.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. Actions from the previous inspection had not been completed. There was a lack of assurance for example monitoring of the WHO checklist. However, they identified and escalated most relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Following our last inspection, we gave the hospital actions that it should take to improve. These included working towards full establishment of staffing to improve access and flow and installing neonatal resuscitation equipment in each birthing room on the birthing centre. At this inspection, whilst the service had a plan to improve staffing in the long term, the number of times the service had to divert women had got progressively worse and the labour ward co-ordinators were still not supernumerary. The head of midwifery told us during the inspection that staff were to take the neonatal resuscitator into each birthing room for every birth until appropriate resuscitation equipment was purchased. However, we were told by all staff that we spoke with that this was not happening.

There was a lack of oversight of procedures designed to improve safety for mothers and babies such as the World Health Organisations five steps to safer surgery. Between April 2019 and December 2019, the room audit had only been completed once. For the maternity theatres audits there were no documented audits in that time period. It was documented under each month and quarterly section "nil return".

Following the inspection, we reviewed the agenda and minutes of the maternity safety champions meetings and found these to appropriately attended and documented.

We saw notices on the walls around the unit informing staff what the top three risks were in the maternity unit in 2019. These were staffing as the top risk, capacity and demand (induction of labour) and non-compliance with continuity of carer. They also informed staff what was being done to remedy these risks such as recruiting more midwives on an incremental basis, changing the way their induction of labour process works and having a dedicated team providing continuity of carer which were aiming for 35% compliance by March 2020.

Staff that we spoke with were aware of the main risks within the service which were pertinent to their area of work.

The service had documented escalation processes in place for incidents such as staffing shortages that may affect care provision for women and babies.

We observed that risks, incidents and performance were discussed at the monthly quality governance board meetings.

Information Management

The service collected data. Data or notifications were submitted to external organisations as required.

Staff had access to the maternity dashboard to read and be informed by and managers monitored the performances documented and utilised these to target any issues.

The maternity dashboard was rag rated (colour coded in red, amber and green) to facilitate easy interpretation of performance and contained nine months of data to assist in identifying any problem areas.

Ward white boards, upon which women's and baby's information were designed and placed to prevent unauthorised access to confidential information.

Engagement

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

We observed a "goodwill at the hill" board which was highlighted a nomination scheme which encouraged nominations about staff who have made a difference and successful staff could receive a certificate towards their revalidation or even a hug in a mug.

Several staff told us that they were supported to develop in their respective careers. One staff member told us her and a colleague were supported throughout to develop to the next level of midwifery leadership but neither of them felt pressured to take on a permanent leadership role if they did not wish to.

The service facilitated the maternity voices partnership meetings that included service users to both feedback about their care within the service and to help develop future care provision.

Learning, continuous improvement and innovation

The service worked with external healthcare professionals and volunteers to provide breast feeding support to new mums and dads in a variety of locations including local department stores.

Services for children and young people

Facts and data about this service

Stockport NHS Foundation Trust has an integrated children's service. The children's Treehouse unit at Stepping Hill Hospital has 32 inpatient beds, a two bed HDU, a four bed surgical day case area and a paediatric assessment unit which is open from 9am till 10pm.

The trust provides care for children with medical, surgical or orthopaedic conditions, both electively and non-electively. The surgical specialities treated at Stockport NHS Foundation trust include emergency surgical and orthopaedic procedures, day case elective lists for ENT, dental, general surgery, ophthalmology and orthopaedics. Daycase dental extraction theatre services are provided by the dental teams in the Maple daycase suite, supported by a paediatric nurse.

The service has eight assessment beds with direct access from GP's and takes children directly from our emergency department for medical assessment and observation. We facilitate open access for children with complex and chronic conditions and of those discharged under the care of our community teams.

We provide shared care with tertiary children's services for a number of conditions. For example, children with cystic fibrosis share care between Stockport NHS FT and a local NHS Foundation Trust.

The integrated service ensures close links between the Inpatient areas and the co located Children's Community Nursing Team (CCNT). This integration aids early discharge of acutely ill patients as well as providing seamless care for children with chronic and complex conditions for example diabetes, epilepsy and respiratory disease.

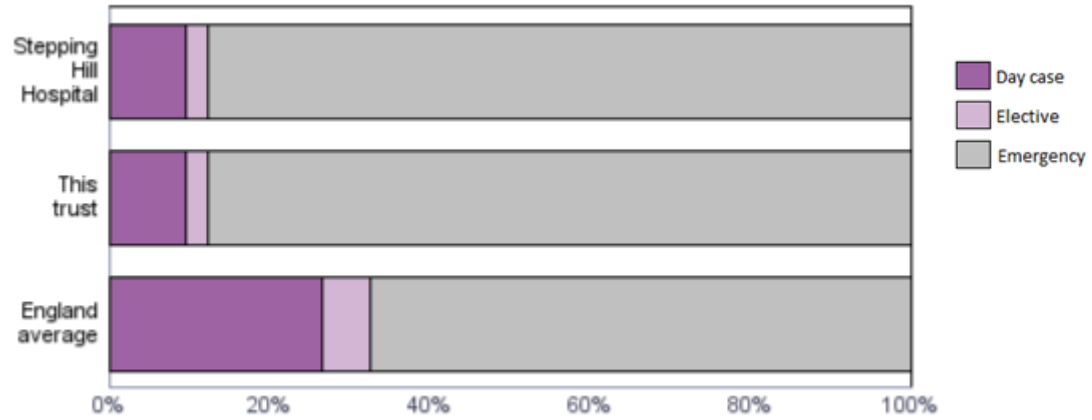
This is a fully integrated paediatric service with the consultant team working across both the acute and community settings, providing continuity of care for children and their families.

(Source: Acute Routine Provider Information Request (RPIR) – Context tab)

The trust had 6,153 spells from July 2018 to June 2019.

Emergency spells accounted for 88% (5400 spells), 9% (580 spells) were day case spells, and the remaining 3% (173 spells) were elective.

Percentage of spells in children's services by type of appointment and site, from July 2018 to June 2019, Stockport NHS Foundation Trust.



Total number of children's spells by Site, Stockport NHS Foundation Trust.

Site name	Total spells
Stepping Hill Hospital	6,153
This trust	6,153
England total	1,156,184

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Trust level

Nursing staff received but did not always keep up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for qualified nursing staff in children's services is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Infection Prevention (Level 1)	75	76	98.7%	90%	Yes
Manual Handling - Object	75	76	98.7%	90%	Yes
Fire Safety 3 years	71	76	93.4%	90%	Yes
Health and Safety (Slips, Trips and Falls)	71	76	93.4%	90%	Yes
Infection Prevention (Level 2)	67	73	91.8%	90%	Yes
Information Governance	73	81	90.1%	90%	Yes
Basic Life Support	66	74	89.2%	90%	No
Medicine management training	63	76	82.9%	90%	No
Manual Handling - People	14	59	23.7%	90%	No

In children's services the 90% target was met for six of the nine mandatory training modules for which qualified nursing staff were eligible.

However, completed training for manual handling did not meet trust targets. Provision of manual handling training had been interrupted due to staff absence, although during inspection we were told of local initiatives being implemented to respond to this issue. Local training records we reviewed on the children's ward during inspection varied with trust records of mandatory training, but also indicated that staff were non-compliant. We were told there had been issues in aligning the electronic records for completed staff training with trust wide systems, and that this was a continuing challenge.

Local records of we reviewed on the neonatal unit indicated 93% compliance with mandatory and role specific training.

Medical staff received but did not always keep up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses from October 2018 to September 2019 at trust level for medical staff in children's services is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection Prevention (Level 2)	12	13	92.3%	90%	Yes
Fire Safety 3 years	15	18	83.3%	90%	No
Health and Safety (Slips, Trips and Falls)	15	18	83.3%	90%	No
Information Governance	16	20	80.0%	90%	No
Manual Handling - Object	14	18	77.8%	90%	No
Infection Prevention (Level 1)	14	18	77.8%	90%	No
Medicine management training	11	15	73.3%	90%	No
Basic Life Support	2	3	66.7%	90%	No

In children's services the 90% target was met for one of the eight mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mandatory training was comprehensive and met the needs of children, young people and staff.

Clinical staff had not completed specific training on recognising and responding to children and

young people with mental health needs, learning disabilities and autism.

Safeguarding

Staff had not always completed the required level of safeguarding training and oversight of this was unclear. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. The trust supplied data only for safeguarding children level 1 training.

Trust level

Rates for completion for the required level of children's level three safeguarding training by nursing staff were low. Systems for oversight of this were unclear.

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for qualified nursing staff in children's services is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 1)	76	76	100.0%	90%	Yes
Safeguarding Adults (Level 2)	68	70	97.1%	90%	Yes
Safeguarding Adults (Level 1)	73	76	96.1%	90%	Yes
Safeguarding Children (Level 3)	41	74	55.4%	90%	No

In children's services the 90% target was not met for the safeguarding training module for which qualified nursing staff were eligible.

During inspection we requested further information from the trust about compliance with level 2 and level 3 children's safeguarding training. We were provided with varying data from different leads in the service which indicated an unclear picture of training compliance, which did not meet trust targets overall. Data provided by the safeguarding team showed completion of safeguarding adults level one was 93%, and safeguarding adults level two was 85%. For safeguarding children training, level one was completed by 93% of staff in the service and level two 90% of staff. At the time of inspection, we were told the training compliance for safeguarding children level three was 51%, for all clinical staff required to complete this. Safeguarding level three training applies for all clinical staff working with children, young people and/or their parents/carers and/or any adult who could pose a risk to children; and who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a child or young person and/or parenting capacity (regardless of whether there have been previously identified child protection/safeguarding concerns or not).

We saw that records of completed safeguarding level three training also varied with the latest trustwide data, which was confirmed during inspection as having been completed by 56% of staff in the service. We were told there had been issues in aligning the electronic records for completed safeguarding training with trust wide systems, and that this was a continuing challenge.

Work with the training team had been in development since January 2019 to identify a safeguarding training strategy. Currently, staff completing level three children's safeguarding were required to demonstrate this through completing 12 hours of safeguarding training over three years. This could include various safeguarding related activities, such as attendance at a safeguarding strategy meeting, or completing a safeguarding supervision or debrief. An online safeguarding training submission form was being implemented for staff to keep a log of their training hours in order to demonstrate this. However, at the time of our inspection, this appeared to still be in development, with recording systems unclear. There was a lack of assurance confirming how many staff had completed the required level of safeguarding training, to meet national guidance in 'Safeguarding children and young people: roles and competences for health care staff.' Intercollegiate document, Fourth edition, Jan 2019.

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

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for medical staff in children's services is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children (Level 3)	15	16	93.8%	90%	Yes
Safeguarding Adults (Level 1)	18	20	90.0%	90%	Yes
Safeguarding Adults (Level 2)	14	16	87.5%	90%	No
Safeguarding Children (Level 1)	15	18	83.3%	90%	No
Safeguarding Children (Level 2)	0	1	0.0%	90%	No

In children's services the 90% target was not met for the safeguarding training module for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff knew how to identify children and young people at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The trust had a current safeguarding policy which staff could access through the trust intranet. Local safeguarding flowcharts and details of the trust's safeguarding process were displayed in ward areas for staff to follow. These provided contact details for the Named Nurse, safeguarding children, as well as other key leads such as the Looked after Children Specialist Nurse, and the consultant paediatrician on call. Staff could give examples of the types of safeguarding issues which could present in the service and appeared confident in their knowledge of trust procedures. Staff followed safe procedures for children visiting the ward, ensuring any children were accompanied by an adult during this time.

The named nurse for children's safeguarding described progress in promoting safeguarding awareness and practice in the service over the past 18 months. This had included establishment of a team of children's safeguarding practitioners, comprising 4.2 whole time equivalent band seven nurse roles; and 0.8 band six nurse role. The team engaged in daily walkarounds of different areas, including the children's ward and outpatient area, and the neonatal unit. The children's safeguarding team also attended the emergency department for triage of all paediatric attendances.

Trust systems for oversight of children's safeguarding had also been progressed during this time, with identification of safeguarding groups at executive and service operational levels. These were appropriately attended by designated staff, including the associate director of nursing for children and the named nurse children's safeguarding. The trust's safeguarding group reported to the trust's quality group, to monitor safeguarding risks and escalate any concerns arising in the service. Safeguarding leads told us of reported change in culture and improved safeguarding practice over the past two to three years, arising out of shared learning from serious case reviews and baby deaths. The children's safeguarding team's focus had been to support staff on the children's ward, outpatient unit and neonatal unit to develop their safeguarding knowledge, skills and practice. Further to a serious case review, the children's safeguarding team and neonatal unit had been closely involved in work with the National Safeguarding review board, looking at recommendations around safe sleep. This experience had brought wide learning and change in practice for the service.

The service had effective electronic systems for referral to the local authority multi-agency safeguarding hub, to communicate any urgent safeguarding information. Staff in both the acute and community service had access to these systems.

The safeguarding team maintained a visible daily presence on the children's ward and neonatal unit and were accessible and responsive for staff requests. However, safeguarding supervision was not yet a fully implemented process across the service. There were opportunities for group safeguarding supervision in the ward, but not all staff attended these.

Cleanliness, infection control and hygiene

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

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

The service generally performed well for cleanliness.
Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
Staff followed infection control principles including the use of personal protective equipment (PPE). Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were available in the children's wards and departments we visited. Wall-mounted hand gel dispensers were placed at ward entrances, with notices displayed to prompt visitors to clean their hands before entering the ward.

Routine observational audits of hand hygiene practice were completed on a monthly basis in the neonatal unit, the treehouse children's unit and outpatient department. Results from October 2019 to January 2020 showed average overall compliance of 94% with correct hand hygiene technique. Scores ranged between 100% on the treehouse children's ward in October 2019, to 70% in December 2019, improving to 80% again in January 2020. The neonatal unit maintained 100% hand hygiene through this period, with zero intravenous line infections. Visitors to the neonatal unit were prompted to use hand gel by staff answering the door intercom.

Where we checked different equipment in the wards and departments, we saw this had been labelled with "I am clean" stickers to show when it was last cleaned; all equipment appeared visibly clean.

Cubicles were available if patients required isolation to manage infection risk during their admission. Staff observed infection prevention measures such as barrier nursing for patients with suspected or confirmed infection, if this was identified. Of the ten cubicles on the ward, only

two had ensuite facilities. There were no cubicles available on the paediatric admission unit; if children needed to be isolated, they would be transferred to a ward cubicle if this was available.

CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 9.1 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept children, young people and their families safe. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. We carried out checks of emergency trolleys and resuscitation equipment on the children's ward, neonatal unit and outpatient department during our inspection. We found that daily checks or resuscitation equipment were completed and documented. The service had recently identified a need to ensure ligature cutters were available on emergency resuscitation trolleys, and we saw these were present on the trolleys we checked. Emergency resuscitation equipment could be accessed quickly when needed. On the neonatal unit a transport incubator was available for babies being transferred to other hospitals for care; daily checks of the transport incubator were completed.

Children, young people and their families could reach call bells and staff responded quickly when called.

We checked records of neonatal fridge and freezer temperature checks on the neonatal unit. We saw from these records that the fridge temperature was recorded as out of the specified range, of between four and eight degrees. Although this had been noted – records did not indicate whether this had been reported to the trust's estates department. Following the inspection, the trust clarified that the fridge check form had been amended at the beginning of February to identify that a temperature of -20 or below was required. However, this did not reflect information in the related breast milk policy and these changes had not been discussed, escalated or due process followed on this occasion.

We observed that portable electronic devices had undergone safety checks and records were maintained detailing when these tests had been carried out. All portable electronic equipment we checked was correctly labelled and within the expiry date. The service had enough suitable equipment to help them to safely care for children and young people. Larger equipment, such as hoists for moving and handling, were stored safely on the ward for use when required.

Bedside equipment on the neonatal unit was maintained by the trust's biomedical engineering department; external companies provided emergency response for specialist equipment.
Wards had clean utility and sluice areas, for storage of sundry items and disposal of clinical waste. Staff disposed of clinical waste safely, using different labelled bins and bags appropriately.

Staff monitored entry and exit to the children's ward and neonatal unit. Access to both areas was gained via intercom, with visitors required to state who they were, and the child or baby they were visiting. There had been no security breaches on the neonatal unit during the past 12

months. Security at ward entrances was enhanced by closed circuit TV, with continuous monitoring on display screens at nurses' stations. Out of hours, on the children's ward, the reception desk function was diverted to the nurses' station. Also, during these times, a switch was used to override the reception desk entrance controls and limit any older age children from absconding from the ward.

In the children's outpatient department all children and their families reported to the reception desk, adjacent to the outpatient clinic area. Staff at reception were able to observe children to ensure appropriate access to the clinic area.

Assessing and responding to patient risk

Staff did not always complete and updated risk assessments for each child and young person or take action to remove or minimise risks. Although staff identified and quickly acted upon children and young people at risk of deterioration, we saw that specific risk assessments for young people with mental health needs were not always completed.

Staff did not always deal with specific risk issues. The trust had a procedure to identify risks where people were at risk of suicide, which included an environmental risk assessment for staff to complete when children and young people were admitted with mental health needs. We were informed the ward was not a ligature-free environment, and when young people were admitted for care, they would usually be nursed in a cubicle on the ward. We saw there were frequent admissions to the ward for children and young people with mental health needs. During inspection we reviewed patient records for these patients; in three out of six records, we saw the environmental risk assessment document had not been completed for patients with mental health needs.

Specialist services for children and young people with mental health needs were delivered under service level agreement, by a third party provider. Specialist assessment by young people's mental health practitioners would only commence once the patient was deemed medically fit; also, there was limited provision at weekends for this service. There was no crisis mental health service provision for emergency department and the children's ward to support children and young people being admitted with mental health needs. In the meantime, ward staff would continue to provide for their care. We heard that frequently, staff were unable to provide direct supervision to patients with mental health needs who required this. Staff had not any completed training for care of children and young people with mental health needs; we saw there were challenges for staff to be able to provide appropriate care for children and young people with these needs on the ward. Following inspection we raised our concerns to the trust for immediate attention.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. On the children's ward, staff used paediatric early warning scores (PEWS) to monitor any changes in a child' s condition, and these were acted on as needed. In the neonatal unit, clinical observations were closely monitored and recorded to detect any changes in the condition of babies. On the neonatal unit and children's ward we reviewed nine care records and saw these were completed accurately, with medical review of neonates completed when this were indicated. Staff followed local policy and procedures when babies and children needed to be escalated for medical review. Where we checked these, medical records indicated patients had been reviewed appropriately, in accordance with local guidance.

Staff completed risk assessments for each child and young person on admission to the children's

ward, using a recognised tool, and reviewed this regularly, including after any incident. The ward admission document incorporated an assessment template for recording paediatric early warning scores, including a paediatric sepsis assessment and sepsis pathway. Staff we spoke with had good awareness of sepsis and we saw sepsis information displayed in the ward area.

All ward staff completed basic life support training for children and adults. Staff were trained to respond where children had a deteriorating condition. Data provided by the trust following request indicated 80% (32 out of 42) nursing staff had completed paediatric life support training; 64% of nursing staff had completed advanced paediatric life support training. Seven further band five nurses were planned to complete advanced paediatric life support training in the future.

The children's ward had two commissioned beds for high dependency care, with sixteen nurses having completed the paediatric high dependency course. The off duty rota was completed to ensure a minimum of one appropriately trained nurse on duty per shift to ensure appropriate cover. From 1 November 2019 to the date of inspection there had been two occasions where there had been no appropriately trained nurse available for high dependency care. On these occasions, care had been provided by experienced nurses, with training in advanced paediatric life support skills.

All neonatal nurses had completed newborn life support training, with annual updates of this. The neonatal ward participated in a regional neonatal transfer network, following regionally agreed guidelines for the safe transfer of unwell babies.

Theatre staff ensured children recovering post-operatively were stable and had safe airway recovery before sending for the next child to be brought down to the operating theatre. All theatre staff looking after children had completed paediatric intermediate life support skills training. Post-operatively, two trained theatre nurses were available to support the child during their immediate recovery; theatre staff accompanied children being returned to the ward after their surgery.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Safety huddles were held at the start of each shift, to share all necessary key information to keep children and young people safe. We observed ward handovers between nursing and medical staff, where concerns including children with escalating conditions, important information about safeguarding, incidents and risks, as well as key ward messages were shared. Medical staff held a joint daily handover for the neonatal unit and children's ward.

CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 7.5 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

In the CQC Children and Young People's Survey 2016 the trust scored 9.6 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016)

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills,

training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, however sufficient nursing staff were not always available to meet the needs of patients.

The service provided on the children's ward did not always have enough nursing and support staff to keep children and young people safe. During inspection we saw there were frequent shortages of nursing staff to meet patient needs. The service did not use a tool for planning staffing in response to patient acuity and dependency, although this work was being progressed at the time of inspection. Access to a senior children's nurse was not always available throughout a 24 hour period, and senior ward nurses routinely needed to work in a clinical capacity to provide care on the children's ward. Whilst we saw that all staff worked to ensure patient care was prioritised and safely provided, in response to the needs of children and young people, it was evident there were daily challenges in staffing the children's ward and neonatal units.

Staff were moved between different service areas to support ward staffing needs; this included staff moves from community children's services and the neonatal unit to the children's ward. Not all staff working in the neonatal unit were trained children's nurses. This meant that staff moved to the children's ward were not trained children's nurses. From July 2019 to January 2020 there had been a total of 40 staff moves from the neonatal unit to support staffing shortage on the children's ward. Of these, 25 staff moves occurred in November 2019.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. We were told the staffing allocation for day shifts on the children's ward was based on six qualified nurses and two healthcare assistants for the 32 bed ward, including high dependency care. This meant that nursing care was provided on average at a ratio of one nurse to six patients. This was not in line with national guidance which recommends a ratio of one nurse per four children over age two years and one nurse to three for children under two years. The trust informed us that the staffing levels were in line with the Greater Manchester escalation staffing guidance.

In addition, the two-bed high dependency area required a staffing ration of one nurse to two patients. Between 1 and 5 November 2019 , both the high dependency beds were occupied, with additional children admitted to the ward who required high dependency care. During this time there were between one and four children being nursed on the ward in bays, who required high dependency care. The service had a bed management escalation process to manage times of increased demand and admissions to the ward were limited to accommodate this higher level of staffing requirement.

At the time of inspection, the service was implementing a health roster project on the ward, as part of a trustwide move to full electronic staff rostering. The service was continuing to use a paper based staff rota system alongside establishment of the electronic safecare system, anticipated to complete in April 2020.

On the neonatal unit, staffing was planned to meet guidance from the British association of Perinatal Medicine (BAPM), although senior nursing staff informed us it was not always possible to have a supernumerary shift lead available, in accordance with BAPM guidance. We also saw that during November and December 2019, the required numbers of appropriately trained neonatal nurse staff had not always been available to care for babies in neonatal intensive care, high dependency area and special care baby unit. Data provided by the trust indicated the recommended neonatal nurse staffing levels in relation to acuity and dependency did not meet BAPM guidance in three of 30 days in November; on 12 of 31 days in December. The service

planned to ensure there were always two neonatal nurses who were qualified in speciality available on each shift.

Display boards on the neonatal unit and children's ward indicated the staff number present on each shift.

Trust level

The table below shows a summary of the nursing staffing metrics in children's services at trust level compared to the trust's targets, where applicable:

	Children's services annual staffing metrics						
	October 2018 – September 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	14%	3.5%			
All staff	146.9	13%	17%	3.8%			
Qualified nurses	79.3	14%	19%	4.0%	12,120	142	N/A

NB: We are unable to provide a percentage bank/agency usage as the total number of hours available was not provided. There was also no data provided for unfilled hours

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

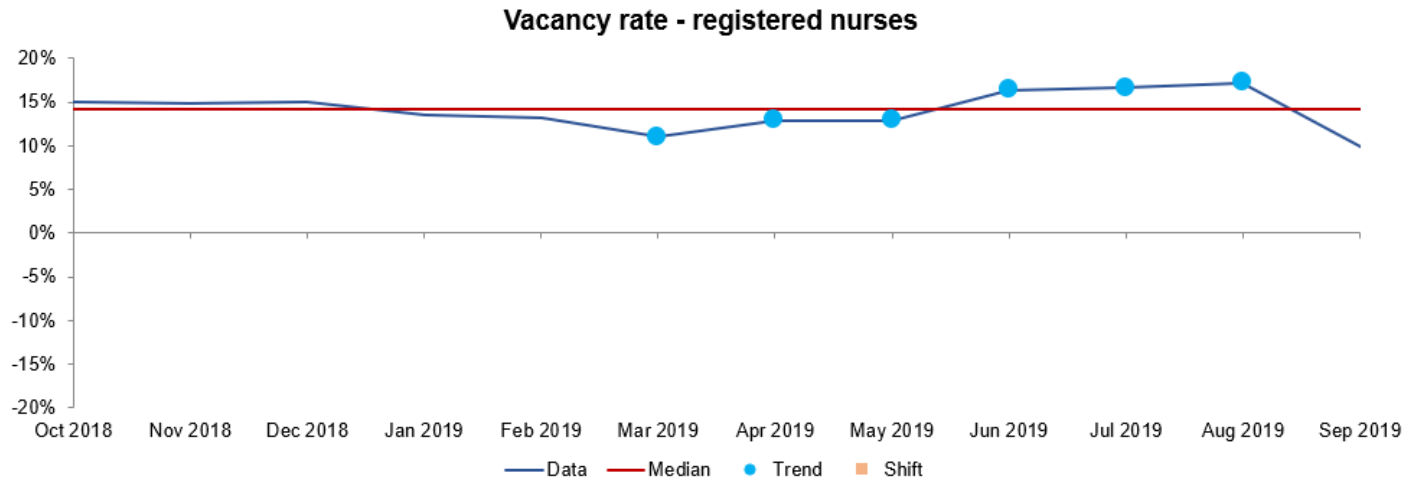
The ward manager could adjust staffing levels daily according to the needs of children and young people.

The number of nurses and healthcare assistants matched the planned numbers.

Nurse staffing rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness, bank use and agency use.

Vacancy rates

The service had low and/or reducing vacancy rates.



Monthly vacancy rates over the last 12 months for registered nurses show an upward trend from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The service was undertaking recruitment of new nursing posts at the time of inspection. Previously, funding resource had been identified for six band 5 posts; more recently this had been reviewed in order to offer four band six vacancies. It was anticipated this might provide an improved possibility for recruitment of more experienced children's nursing staff.

Medical staffing

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

The service had enough medical staff to keep children and young people safe, although there were occasional gaps in cover by specialty and associate specialist doctors, reflecting a national profile. Since the last inspection, consultant cover had been redesigned to provide senior medical staff cover until 10 pm each weeknight. The service had 13 paediatricians who provided this senior medical cover for staff.

The medical staff matched the planned number.

Trust level

The table below shows a summary of the medical staffing metrics in children's services at trust level compared to the trust's targets, where applicable:

	Children's services annual staffing metrics						
	October 2018 – September 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	14%	3.5%			
All staff	146.9	13%	17%	3.8%			
Medical	18.3	4%	27%	0.4%	1,076	284 (12%)	1,011

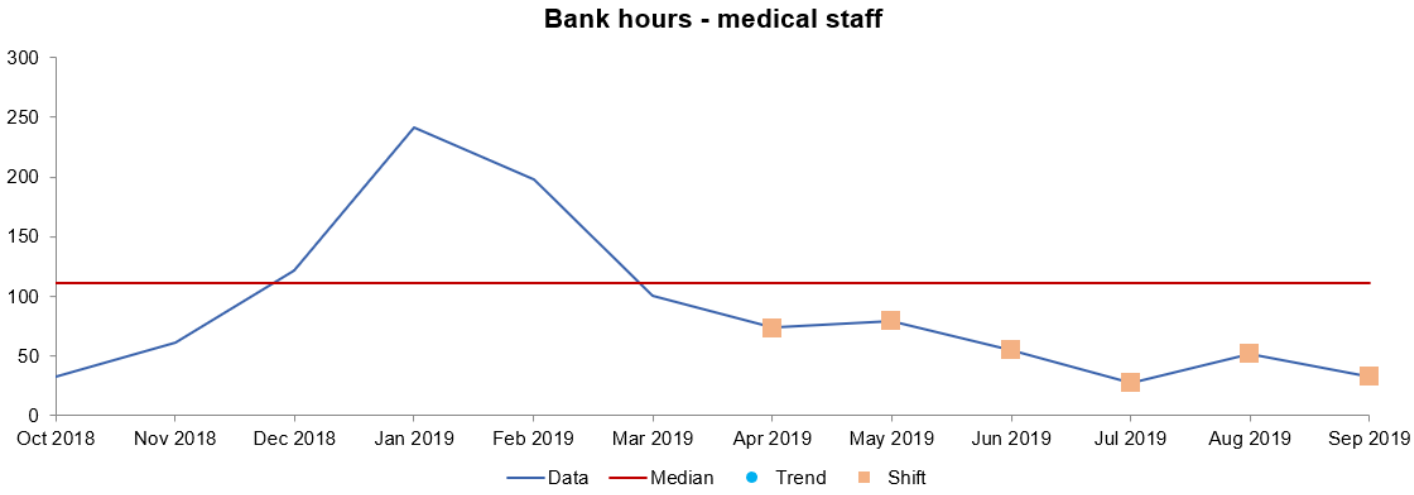
staff					(45%)		(43%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within children's services were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and locum use.

Bank staff usage

The service had reducing rates of bank and locum staff.



Monthly bank use over the last 12 months for medical staff show a downward shift from April 2019 to September 2019.
(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Managers could access locums when they needed additional medical staff.

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

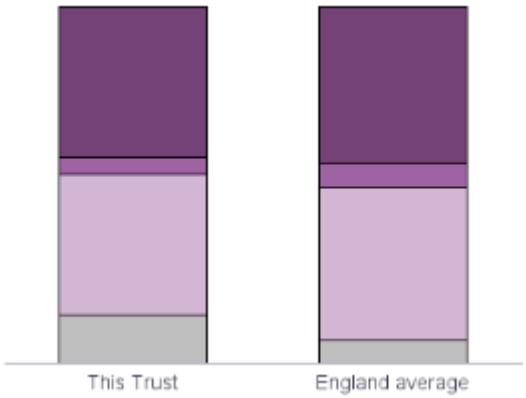
Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In June 2019, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 30 whole time equivalent staff working in services for children and young people at Stockport NHS Foundation Trust

	This Trust	England average
Consultant	42%	44%
Middle career^	5%	7%
Registrar Group~	39%	43%
Junior*	14%	6%



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (Styr) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of children and young peoples' care and treatment. Although records were clear, up-to-date and easily available to all staff providing care, care plans and risk assessments were not always accurately documented.

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

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely in locked trolleys on the children's ward, outpatient department and neonatal unit. The service was using paper records at the time of inspection; however, plans were progressing to implement full electronic patient records across the service. Staff described having a 'paper light' approach currently. Staff followed the trust's standard operating procedures for documentation in medical and nursing records. We checked ten sets of patient records and found these were completed to a good standard, with one isolated occasion of a record incomplete.

However, we saw fluid and diet sheets were not fully completed in four out of eight care plans we reviewed on the children's ward, and three of six risk assessments were incomplete

The service completed routine audits of records.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We checked seven prescription records and found these were correct, with the exception of one prescription card where allergies were not documented. Staff wore red tabards to indicate they were on medicines rounds, to limit potential distractions and interruptions.

Staff reviewed children and young people's medicines regularly and provided specific advice to children, young people and their families about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs prescribed for children were securely stored in a locked cabinet located within the treatment room; the treatment room had keypad-controlled access. Records for administration of controlled drugs were signed by two nurses, in accordance with trust procedures.

Staff followed current national practice to check children and young people had the correct medicines. Pharmacists attended the children's ward daily to check medicines and stocks

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Incidents

Staff recognised incidents and near misses and reported them appropriately. Although managers investigated incidents, learning from incidents was not always shared in the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported incidents using the trust's electronic incident reporting system. Staff received individual feedback following incident reporting, and any wider learning from incidents was shared in team communications, including emails from managers, paediatric and trust-wide safety bulletins. During inspection we saw Information boards indicating there had been three medication errors on the children's ward during December 2019. We spoke with three trained nursing staff during inspection who were unaware what these medication errors were.

We also saw one recent report concerning a serious incident on the neonatal unit. Although the staff who had been providing care had received a debrief following the incident, not all staff had shared feedback from this, despite there being a weekly ward meeting to review concerns and incidents. Senior medical staff told us they had assurance of evidence based care having been followed, with a shared view of this incident as unanticipated and unavoidable. The incident had been thoroughly reviewed and was proceeding through investigation at the time of inspection.

During inspection we accompanied a young patient and their parent being brought to the anaesthetic room prior to surgery. We saw how the ward staff checked the patient's name band and records to be correct. Staff escorting the patient to the anaesthetic room changed over during this transfer, due to one nurse needing to return to the ward. During the checking in procedure in the anaesthetic room, staff identified that the incorrect patient notes had been handed over. The escorting member of staff returned to the ward to obtain the correct patient notes and returned to the anaesthetic room. Two days later we saw this had not yet been reported as an incident, or any feedback shared with other staff.

Staff told us they would raise an incident regarding any staffing shortages during shifts. Between June and December 2019 there had been 22 staffing incident reports raised for the service, with 15 of these relating to neonatal unit staffing. All these incidents were recorded as no harm incidents.

Incidents were reviewed by senior managers in a monthly risk meeting for the women's, children's and diagnostics business unit. Any incidents assessed as high risk, or incidence of mortality in the neonatal unit were reviewed in clinical excellence group meetings, on alternate months. Neonatal unit managers identified staffing, and isolated medication incidents, as current themes from incident reporting.

Included in incident reports, we were informed of eight incidents of young people absconding from the children's ward from June 2019 to January 2020. Two of these patients were recorded as having absconded a second time as part of the same incident record. All incidents were reported as no harm outcomes and actions followed up with security and police service as per trust protocol. Overall the service identified 22 incidents with regard to children and young people with mental health needs in the twelve month reporting period prior to inspection. Four of these were recorded as low harm incidents, arising from self-harm occurring during admission.

Never Events

The service had no never events on any wards.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust reported no never events for children's services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in which met the reporting criteria set by NHS England from October 2018 to September 2019. A breakdown of incidents by incident type are below.

Incident type	Number of incidents	Percentage of total
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1	50.0%
Adverse media coverage or public concern about the organisation or the wider NHS	1	50.0%
Total	**2**	**100.0%**

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff followed the duty of candour principles in their daily work, maintaining open communication with service users.

Staff received individual feedback from investigation of incidents and managers shared updates of learning in staff bulletins. Themes identified in recent incidents included ten medication incidents for neonatal and perinatal care, six staffing incidents. We saw there was less opportunity for face-to-face meeting in the service, beyond the daily safety huddles due to the challenge of staffing.

Managers investigated incidents thoroughly and debriefed and supported staff after any serious incident. Any incidence of child death was reviewed at a monthly paediatric mortality review group meeting. This would be attended predominantly by medical staff, although was open to

nursing and other staff also.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.

Safety thermometer data was displayed on wards for staff, children, young people and their families to see.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Staff used the safety thermometer data to further improve services. The service was developing a tailored version of the safety thermometer for more relevant application to paediatrics.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2018 to August 2019 for children's services.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

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

Staff had access to current policies and guidance though the trust's intranet. All policies we reviewed during the inspection were up to date and appropriately referenced national guidance. The service identified clinical care plans specific to children's conditions. Staff could access care plans for children's conditions on the children's ward and neonatal unit.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families.

Pain relief

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

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used scoring charts to record children's pain levels as part of early warning scores observations.

Children and young people received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

However, staff did not always fully and accurately complete children and young people's fluid and nutrition charts where needed. We saw that fluid and diet sheets were not fully completed in four out of eight care plans we reviewed on the children's ward.

Specialist support from staff such as dieticians and speech and language therapists was available for children and young people who needed it. Dieticians completed nutritional assessments for children and young people with eating and swallowing disorders. Dieticians provided support for babies on the neonatal unit, providing staff with appropriate advice regarding care plans.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards.
The neonatal unit achieved 100% in saving lives audit.
Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Paediatric diabetes audit

The table below summarises the trust's performance in the 2018 National Paediatric Diabetes Audit.

Metrics *(Audit measures)*	Trust performance	Comparison to other hospitals	Met national standard?
Completion rate for key health checks for patients aged 12+ *(There are seven key care processes recommended by NICE for patients with Type 1 diabetes that should be performed at least annually)*	86.2%	Within expected range	No current standard
Case-mix adjusted mean HbA1c (*HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled. This measure is provided for benchmarking against other providers during an audit year)*	64.7	Better than expected	No current standard
Median HbA1c *(This measure is provided to give an indicator of how performance has changed between the previous and*	61.5	Clinically significant improvement	No current standard

latest audit reports. A change of 1 mmol/mol is deemed to be clinically significant)			

(Source: National Paediatric Diabetes Audit)

Managers and staff used audit results to improve patient outcomes.

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

National Neonatal Audit Programme

The table below summarises Stepping Hill hospital's performance in the 2018 National Neonatal Audit Programme against measures related to neonatal care.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Met national standard?**
Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc? (*Low body temperature on admission is associated with increased complications, such as hypoglycaemia, jaundice and respiratory distress, and death in pre-term infants)*	58.9%	Within expected range	Did not meet
Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? *(Timely consultation with parents/carers is crucial to allaying fear and anxiety and improves the parent/carer experience)*	94.1%	Better than expected	Did not meet
Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP) (*ROP is a preventable cause of blindness in pre-term infants provided it is detected and treated in a timely way)*	97.6%	Within expected range	Did not meet
Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age? **(***It is important that the development of pre-term babies is monitored by a paediatrician or neonatologist after discharge from the neonatal unit)*	66.0%	Within expected range	Did not meet

(Source: National Neonatal Audit Programme)

Emergency readmission rates within two days of discharge

The data shows that from February 2018 to January 2019 there was a no specialty at the trust which had eight or more readmissions for patients following elective admission, either under the

age of one or aged between 1-17.

The data shows that from February 2018 to January 2019 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average for Paediatrics.

For patients aged 1-17 years old, there was a lower percentage of patients readmitted following an emergency admission compared to the England average for Paediatrics, and a lower percentage of patients readmitted following an emergency admission compared to the England average for General surgery.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment Speciality (February 2018 to January 2019)				
Speciality	**Stockport NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	2.7%	1,650	45	3.6%

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment Speciality (February 2018 to January 2019)				
Speciality	**Stockport NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	1.6%	3,195	50	2.9%
General Surgery	3.8%	400	15	4.4%
No other specialty at this trust had eight or more readmissions.				

(Source: Hospital Episode Statistics)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From March 2018 to February 2019 the trust had insufficient data for the percentage of patients under the age of one who had multiple readmissions for asthma, diabetes or epilepsy.

The trust performed similar to the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and epilepsy.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years). (March 2018 to February 2019)				
	Stockport NHS Foundation Trust			England
Long term condition	Multiple admission rate	At least one admission (n)	Two or more admissions (n)	Multiple admission rate
Asthma				
Under 1	-	-	-	9.7%
1 to 17	15.4%	130	20	15.9%
Diabetes				
Under 1	-	-	-	17.6%
1 to 17	*	35	*	12.8%
Epilepsy				
Under 1	*	*	*	33.7%
1 to 17	27.3%	55	15	28.9%

Notes: To protect patient confidentiality, figures between 1 and 5 and their associated proportions have been suppressed and replaced with "" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed. The "- "(a hyphen) in the table indicates that there were no admissions for these long term condition or age groups.*

(Source: Hospital Episode Statistics)

Competent staff

The service did not always support new staff to ensure they were competent for their roles. Managers appraised staff's work performance, but completion rates did not meet trust targets.

The clinical educators supported the learning and development needs of staff. Two clinical practice facilitators were available on the children's ward, working together in a job-share role through the week. A deputy matron role had been introduced on the children's ward to provide support for the matron and clinical practice facilitators, as well as to focus on quality improvement approaches in the service.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families.

Staff in different parts of the service had developed their knowledge and expertise in specialist areas, acting as champions in different clinical practice. Various champions were available , including for safeguarding; infection prevention and control; moving and handling; tissue viability nursing; aseptic no touch technique. Champions attended additional training and meetings for their specialist area, supporting other staff with learning updates and advice where needed. Play specialists were trained in different clinical competencies, including cannulation techniques, observations, and urine tests. Play specialists were able to use their expertise during these activities to offer tailored support for children. Champions attended additional training and

meetings for their specialist area, supporting other staff with learning updates and advice where needed.

A breastfeeding specialist nurse was available on the neonatal unit to support breastfeeding mothers. All neonatal nursing staff attended an annual breastfeeding study day. The neonatal unit also had a safe sleep champion to promote this awareness to parents. The neonatal unit did not have access to a practice education facilitator, although this vacancy was being advertised at the time of inspection.

Neonatal nurses participated in benchmarking at regional neonatal network meetings and engaged in different network activities. Staff had developed and induction pack, to share information and learning from the network , with attendance at a network study day on family integrated care. The regional network offered an induction programme for neonatal nurses; six new neonatal nurses who had joined the service in the past six months were completing this. An assistant practitioner on the unit co-ordinated discharge from the neonatal unit, ensuring all parents have had information and advice for parentcraft and safe sleeping.

Sixteen nurses were trained with high dependency care competencies on the children's ward. We were told this training had been available previously in a service level agreement with an external provider, but had more recently been provided through an 'in-house' training. Managers were reviewing the possible alternative options for reinstating this training, at the time of inspection, although there were also funding challenges with this. We frequently heard from staff during our visit that in practice, less experienced staff would be supervised less closely due to the daily workload demands. This gave rise to some anxiety, particularly for more junior staff working in the high dependency unit. Staff described this as a 'daunting experience'.

One member of nursing staff was being supported to complete a mental health first aid course.

Managers gave all new staff a full induction tailored to their role before they started work. Clinical practice facilitators on the children's ward provided new staff with an information booklet, and a new staff study day, incorporating training in key skills and competencies.

Staff told us that some staff did not always complete their time as supernumary when joining the service; this was due to staffing demands. All registered staff are required to be supernumerary for six weeks.
Senior ward staff on both the children's ward and neonatal unit commented there had been a number of experienced staff who had retired over the last 12 months, or were due to retire in the coming year. Consequently, there had been a challenge in managing skill mix appropriately in the service. To assist towards this, two advanced paediatric nurse practitioners were currently undergoing training. It was anticipated these practitioners would be able to provide enhanced specialist support for staff on the ward in future. Senior nurse managers were also focussing on building capacity within the band six staffing for the neonatal service, to provide appropriate skill mix for the neonatal unit.

Appraisal rates

Managers did not always support staff to develop through yearly, constructive appraisals of their work.

From 5th October 2018 to 4th October 2019, 80.3% of staff within children's services at the trust received an appraisal compared to a trust target of 95%.

Trust level

Staff group	5th October 2018 to 4th October 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Allied Health Professionals	2	2	100.0%	95%	Yes
Administrative and Clerical	15	16	93.8%	95%	No
Nursing and Midwifery Registered	63	79	79.7%	95%	No
Medical and Dental	14	18	77.8%	95%	No
Additional Clinical Services	16	22	72.7%	95%	No
Total	**110**	**137**	**80.3%**	**95%**	**No**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Where staff had completed their appraisals, staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. However, specialist training courses in paediatric high dependency care were not as available as previously and there were some funding challenges here also. The service were reviewing the alternative possible options.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. Doctors held medical handover meetings which began with a 15 minute communications update, to share any issues arising on the neonatal unit and children's ward. We observed a medical handover during inspection where we heard consultant paediatricians had met with local GPs to discuss pathways for children with specific health needs, aimed at reducing the need for hospital admission.

Acute nursing services provided as part of the community team had access to community consultant paediatricians based in the respite care facility. Individual care plans for children with complex disabilities and health needs were followed across the health, education and social care system in the locality. There was a comprehensive approach to ensure holistic care for these children, young people and their families and carers.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. We observed safeguarding case meetings attended by trust staff and professionals from other agencies, including psychologists from mental health services, and social workers from the local authority.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health or depression.
In the children's outpatient department, we saw appointments were co-ordinated for children with

disabilities, providing a ‘one stop shop’ service. We spoke with parents of children with disabilities, who had been able to see the paediatrician, occupational therapist, dietician and physiotherapist during their attendance.
The discharge co-ordinator on the neonatal unit liaised with local health visiting services for all babies being transferred to specialist neonatal units, and for all babies discharged to home.

CQC Children and Young People’s Survey 2016 – Q23

In the CQC Children and Young People’s Survey 2016 the trust scored 8.7 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016)

Seven-day services

Not all key services were routinely available seven days a week to support timely care for children, young people and their families.

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants or senior medical staff, depending on the care pathway.

Staff could call for support from doctors and other disciplines, although not all of these were available 24 hours a day, seven days a week. Physiotherapy services were available on weekdays, with out of hours and weekend provision for respiratory care.

Mental health services were provided in a service level agreement, with specialist mental health practitioners available to assess children with mental health needs. There were two assessment slots available each weekday; weekend cover was available only on one day, either Saturday, or Sunday alternately.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on ward, outpatient department and neonatal unit.

Staff assessed each child and young person’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Support for smoking cessation and awareness of this was promoted on the neonatal unit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and families who lacked capacity to make their own decisions. Staff had not been trained in how to care for children and young people who were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff completed training in consent, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). Consent for treatment was clearly documented on individual patient records for children and young people. We saw how staff routinely sought consent of children and young people in the course of providing care. They used phrases such as ‘will that be all right?’, and checked patients were happy to proceed with different aspects of care,

using age appropriate communication.

We saw during inspection there were several children admitted to the children's ward who were experiencing mental ill health. However, mental health assessments were not completed until several days after admission. Nursing staff were required to continue providing care for these patients during this time, although they had not completed any training for this.

Staff made sure children, young people and their families consented to treatment based on all the information available. Where children and young people lacked capacity to consent due to illness or disability, staff communicated with parents and carers to explain what was required, and the reasons for this, when obtaining their consent.

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

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

Mental Capacity Act and Deprivation of Liberty training completion

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

Trust level

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

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

A breakdown of compliance for MCA/DOLS training courses from October 2018 to September 2019 at trust level for qualified nursing staff in children's services is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	67	74	90.5%	90%	Yes

In children's services the target was met for the MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2018 to September 2019 at trust level for medical staff in children's services is shown below:

Training module name	October 2018 to September 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act Level 1	11	14	78.6%	90%	No

In children's services the target was not met for the MCA/DOLS training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Other CQC Survey Data

CQC Children and Young People's Survey 2016 Data

The trust performed about the same as than other trusts for four questions relating to effectiveness in the CQC Children and Young People's Survey 2016. One question did not receive enough responses to provide a score.

CQC Children's Survey questions, effective domain, Stockport NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG	KLOE
21	Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.6	About the same as other trusts	E3
9	Did staff play with your child at all while they were in hospital?	0-7 adults	7.3	About the same as other trusts	E4
19	Did different staff give you conflicting information?	0-7 adults	8.3	About the same as other trusts	E4
33	During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	8.2	About the same as other trusts	E4
54	Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	No Score	No Score	E4

(Source: CQC Children and Young People's Survey 2016)

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

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance.

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were sensitive and responsive when caring for babies, children, young people and their families. Staff took time to interact with babies, children, young people and their families in a respectful and considerate way.

Staff treated children with kindness and compassion, showing care for babies, children and young people, their parents and carers. There was a compassionate, child and family-centred culture in day to day practice through the service. Staff were motivated to provide services which were focussed on the needs of babies and children, young people and their families.

Staff were considerate of children's privacy and dignity, discreetly providing personal care when required. Children, young people and their families said staff treated them well and with kindness. Friends and family responses scored highly for neonatal service, with 100% positive feedback. A friends and family 'tree' was available for parents and visitors to add their comments, on paper notes in the shape of leaves.
Staff understood and respected the personal, cultural, social and religious needs of babies, children, young people and their families and how they may relate to care needs. Staff ensured policies were followed to maintain patient confidentiality during care and treatment.
Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.
During our inspection we saw staff supported each other to provide a holistic approach to care and treatment, engaging with families and carers to provide this.

CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts for all questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, compassionate care, Stockport NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG	KLOE
10	Did new members of staff treating your child introduce themselves?	0-7 adults	9.1	About the same as other trusts	C1
14	Did you have confidence and trust in the members of staff treating your child?	0-15 adults	9.1	About the same as other trusts	C1
22	Were members of staff available when your child needed attention?	0-15 adults	7.8	About the same as other trusts	C1
42	Do you feel that the people looking after your child were friendly?	0-7 adults	9.2	About the same as other trusts	C1
43	Do you feel that your child was well looked after by the hospital staff?	0-7 adults	9.1	About the same as other trusts	C1
44	Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	8.2	About the same as other trusts	C1
58	Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	6.4	About the same as other trusts	C1
64	If you had any worries, did a member of staff talk with you about them?	8-15 CYP	8.5	About the same as other trusts	C1
74	Do you feel that the people looking after you were friendly?	8-15 CYP	9.5	About the same as other trusts	C1

75	Overall, how well do you think you were looked after in hospital?	8-15 CYP	9.1	About the same as other trusts	C1

(Source: CQC Children and Young People's Survey 2016)

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families and those close to them help, emotional support and advice when they needed it.

Staff supported children, young people and their families who became distressed in an open environment, and helped them maintain their privacy and dignity. We saw how staff quickly responded where children appeared anxious or became upset, providing gentle reassurance and encouragement. Play specialists were skilled at using distraction techniques to support children during treatment procedures. Play specialists provided continuing support for individual patients and other staff, to promote emotional wellbeing for children and young people receiving care. Staff demonstrated empathy when having difficult conversations or sharing bad news. All staff were highly aware of the family experience related to care if children and young people and worked to support family members and carers where they could.
Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's wellbeing. Parents were invited to accompany their child to theatre reception when they were having surgery; one parent would be able to accompany the child into the anaesthetic room, to help to ease children's anxieties.

CQC Children and Young People's Survey 2016

The trust performed about the same as other trusts for all questions relating to emotional support in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, emotional support, Stockport NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG	KLOE
7	Was your child given enough privacy when receiving care and treatment?	0-7 adults	9.4	About the same as other trusts	C3
29	If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	8.9	About the same as other trusts	C3
45	Were you treated with dignity and respect by the people looking after your child?	0-7 adults	9.2	About the same as other trusts	C3
65	Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	9.1	About the same as other trusts	C3

67	If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	9.3	About the same as other trusts	C3

(Source: CQC Children and Young People's Survey 2016)

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff used appropriate prompts when treating young children, frequently checking that children were comfortable and offering different choices of activity where they could.
Where possible , parents and carers were invited to be involved as partners in care, to help children have a positive experience of their treatment. Staff supported children, young people and their families to make informed decisions about their care.
We observed a safeguarding strategy meeting involving other agencies, and saw how staff supported children and young people to participate in these. Staff ensured the voice of the child was fully acknowledged and reflected in the decision making processes.
Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this.
Children, young people and their families gave positive feedback about the service.
Staff gave examples of how they used patient feedback to improve the quality of care they provided. Staff on the neonatal unit had recently introduced a family integrated care model, to enable parents to be closely involved in care of their babies. This had helped to create a 'think family' holistic approach on the unit.

CQC Children and Young People's Survey 2016

The trust performed better than other trusts for one question, and about the same as other trusts for 19 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016. There was one question where there was not enough responses to provide a score.

CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Stockport NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG	KLOE
11	Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	9.4	About the same as other trusts	C2
12	Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	8.2	About the same as other trusts	C2

13	Did a member of staff agree a plan for your child's care with you?	0-15 adults	9.2	About the same as other trusts	C2
15	Did staff involve you in decisions about your child's care and treatment?	0-15 adults	8.3	About the same as other trusts	C2
16	Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.8	About the same as other trusts	C2
17	Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	8.4	About the same as other trusts	C2
18	Were you able to ask staff any questions you had about your child's care?	0-15 adults	9.1	About the same as other trusts	C2
31	Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.5	About the same as other trusts	C2
32	Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.4	About the same as other trusts	C2
34	Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.6	About the same as other trusts	C2
39	When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	8.4	About the same as other trusts	C2
41	Do you feel that the people looking after your child listened to you?	0-7 adults	8.7	About the same as other trusts	C2
59	Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	9.4	About the same as other trusts	C2
60	When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.8	About the same as other trusts	C2
61	Did you feel able to ask staff questions?	8-15 CYP	9.7	About the same as other trusts	C2
62	Did the hospital staff answer your questions?	8-15 CYP	9.5	About the same as other trusts	C2
63	Were you involved in decisions about your care and treatment?	8-15 CYP	6.6	About the same as other trusts	C2
66	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	No Score	No Score	C2
69	Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	9.7	About the same as other trusts	C2

70	Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	9.1	About the same as other trusts	C2
72	When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	8.7	Better than other trusts	C2

(Source: CQC Children and Young People's Survey 2016)

Is the service responsive?

Service delivery to meet the needs of local people

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

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

Facilities and premises were appropriate for the services being delivered. The children's unit included an eight bed admission bay for direct referral from general practitioners. The children's unit provided care for medical inpatients, emergency surgery and daycase surgery on the ward. Within the children's ward there was a large playroom that was situated centrally, with easy access for all children and their parents or carers. This room was welcoming and uncluttered, providing a variety of different age appropriate toys.
The children's outpatient department offered children's appointments in a range of paediatric specialities, as well as a daycase investigations department. Outpatient appointments were routinely held during Monday to Friday; on our inspection we saw clinics available for paediatric epilepsy, general paediatrics, and specialist clinics for looked after children, under care of the local authority. Designated clinic rooms were available for child protection medical assessments. Capacity clinics for dermatology were currently being held on Sundays; frenulotomy clinics were regularly provided on Sundays for babies with tongue tie. Two physiotherapy treatment rooms were available in the children's outpatient department.
A community respite care facility was available for children and young people with complex needs and disabilities. Permanent staff were based at the facility, but were also available to move across the service when this was required. When children were admitted to the ward from the respite care facility, staff would provide continued care for these children on the ward, assisting in ward staffing during these times.
On the children's ward, staff could refer children to mental health practitioners for assessment and advice. Mental health assessments would only proceed once all medical treatment had completed and the child was medically optimised. Children with complex disabilities, including learning disability, had access to specialist support from different practitioners, according to their needs. Support available included physiotherapy; occupational therapy; dietician; speech and language therapy; specialist paediatric nurses for children with diabetes, epilepsy and respiratory conditions; and learning disability services.
The service had systems to help care for children and young people in need of additional support, specialist intervention and planning for transition to adult services.
Managers monitored and took action to minimise missed appointments. Text message reminders were sent for children's outpatient appointments. Managers ensured that children, young people and their families who did not attend appointments were contacted. Staff followed

up any missed appointments in contact with parents and carers. Any safeguarding concerns were identified and trust safeguarding procedures followed where these were identified from missed appointments.

CQC Children and Young People's Survey 2016

The trust performed better than other trusts for one question, and about the same as other trusts for the remaining 16 questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, responsive domain, Stockport NHS Foundation Trust

Question Number	Question	Age group	Trust score	RAG	KLOE
4	For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	10.0	Better than other trusts	R1
5	Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	9.2	About the same as other trusts	R1
25	Did you have access to hot drinks facilities in the hospital?	0-15 adults	8.8	About the same as other trusts	R1
26	Were you able to prepare food in the hospital if you wanted to?	0-15 adults	6.0	About the same as other trusts	R1
28	How would you rate the facilities for parents or carers staying overnight?	0-15 adults	7.2	About the same as other trusts	R1
55	Was the ward suitable for someone of your age?	12-15 CYP	7.8	About the same as other trusts	R1
8	Were there enough things for your child to do in the hospital?	0-7 adults	8.3	About the same as other trusts	R2
24	Did your child like the hospital food provided?	0-7 adults	5.8	About the same as other trusts	R2
37	Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.9	About the same as other trusts	R2
38	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.9	About the same as other trusts	R2
40	Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	8.5	About the same as other trusts	R2
56	Were there enough things for you to do in the hospital?	8-15 CYP	7.2	About the same as other trusts	R2

57	Did you like the hospital food?	8-15 CYP	7.4	About the same as other trusts	R2
71	Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	8.3	About the same as other trusts	R2
73	Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	8.4	About the same as other trusts	R2
2	Did the hospital give you a choice of admission dates?	0-7 adults	2.3	About the same as other trusts	R3
3	Did the hospital change your child's admission date at all?	0-7 adults	9.4	About the same as other trusts	R3

(Source: CQC Children and Young People's Survey 2016)

Meeting people's individual needs

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

Wards were designed to meet the needs of children, young people and their families. Play specialists assessed every child aged over three year old on the ward each day, providing age appropriate activities and distraction techniques where this was required. Staff worked to provide this cover, between 7.00 am and 8.00 pm Monday to Friday, and 9.00am to 4.30pm at weekends. Play specialists also offered parents of under three year olds some care for their child, if parents needed to have a break.

Staff used transition plans to support young people moving on to adult services. The service saw children aged over 16 years who remained under the care of a paediatrician, particularly where they had complex needs and disabilities. We saw how staff supported children and young people living with complex health care needs, by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff had access to communication aids to help children, young people and their families become partners in their care and treatment. Parents appreciated the co-ordinated approach to their child's care.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Access to interpreters was identified when required; during inspection we saw one family on the children's ward being supported by an interpreter. Staff said the service was responsive and interpreters were available in a timely way, either via telephone or face to face interpreter services.
Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. Chaplaincy services were available for children, young people and their families and carers on the children's ward and neonatal unit.
A wide array of different information was provided for children, young people and their parents and carers. Ward leaflets were available providing general advice about specific paediatric conditions, such as febrile convulsions, as well as advice for going home from the children's unit. Information was displayed throughout the ward and neonatal unit; on the neonatal unit we saw

information about brain development of neonates; baby bliss charter and support groups and family integrated care.
The service used feedback from parents and carers to identify where improvements could be made. We saw the parent's area on the neonatal unit was being updated to include a siblings play area, following this feedback. A mother-friendly room was available for mothers to use for expressing milk for their babies.

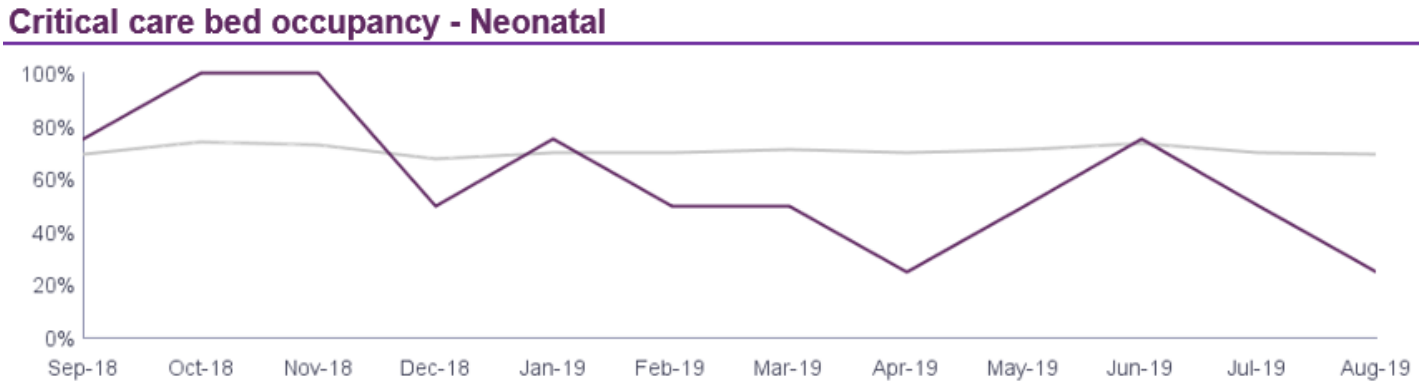
Access and flow

People could mostly access the service when they needed it and received the right care promptly. However there had been occasions where the children's ward had been closed during times of high demand. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Neonatal Critical Care Bed Occupancy

Managers and staff worked to make sure children and young people did not stay longer than they needed to.

From September 2018 to August 2019, the trust has seen neonatal bed occupancy fluctuate monthly between 20% and 100%. Generally, occupancy was lower than the England average.



Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled appointments and operations to a minimum.

When children and young people had their appointments and operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

The service moved children and young people only when there was a clear medical reason or in their best interest.

During peak times of demand, including periods of winter pressure, measures were in place to ensure safe patient care. From 1 November 2019 to the date of inspection, there had been eight

occasions when the children's unit had been closed to admissions.

Managers and staff worked to make sure that they started discharge planning as early as possible. When young people with complex disabilities were admitted to the ward, care planning and multidisciplinary teamworking was established to enable discharge as early as possible, once children were medically fit. Staff planned children and young peoples' discharge carefully, particularly for those with complex mental health and social care needs

Managers monitored the number of delayed discharges. Managers recognised the impact of delayed discharge for children and young people with mental health needs who were awaiting transfer to specialist inpatient mental health facilities. Staff supported children, young people and their families when they were referred or transferred between services.

The children's ward incorporated a paediatric admission unit, with a triage bay, two examination bays and three bed spaces. The paediatric assessment unit was available between 9.00 am and 10.00 pm. The admission unit frequently opened until 2.00 am, however was dependent on nurse staffing for this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Children, young people and their families knew how to complain or raise concerns. The service received a low number of complaints overall. Whenever any concerns were identified, staff communicated directly with children, young people, and their parents or carers to resolve these at the time, as far as was possible. The neonatal unit received one complaint during the last twelve months; this was related to expectations of treatment. During the inspection we were aware of one complaint on the children's ward which was being responded to by senior staff in the service.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Summary of complaints

Trust level

From October 2018 to September 2019 the trust received 22 complaints in relation to children's services at the trust (5.3% of total complaints received by the trust). The trust took an average of 36.8 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be completed within 45 working days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Other (specify in comments)	11	50.0%
Patient Care	4	18.2%
Communications	3	13.6%
Values & behaviours (staff)	1	4.5%
Waiting times	1	4.5%
Appointments	1	4.5%
Admin/policies/procedures (inc patient record)	1	4.5%

Total	**22**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From September 2018 to September 2019 there were eight compliments about children's services, 0.6% of the total compliments at the trust.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

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

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. Although they understood the issues the service faced, they were not always able to prioritise these. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Staff we spoke with were positive about their immediate managers' leadership, although felt less connected with the trust's leadership. Staff were generally aware of the structures and processes applying to their services.

We spoke with leaders of women's, children's and diagnostics business unit who had an understanding of the issues the service faced as a whole. They had less influence on some of the more immediate demands facing the service, however, with provision for children and young people with mental health needs being key amongst these. This was identified as one of the top risks in the service.

Leaders were aware of the regional system-wide issues that had a bearing on service development. However, this also had some impact on leaders' ability to make decisions for directing local progress currently. Leaders shared the view that the profile of children and young people's services had become more established since the last CQC inspection, with the service now having greater recognition at executive level. The associate director of nursing for children's service had been appointed in December 2017, undertaking reviews and leading development of the service since this time. Leaders described one of the key service developments as the provision of an integrated care service across the acute and community health sector, for children and young people. They described this as being able to provide a more responsive and targeted service for people using the service.

Leaders encouraged and supported staff in their development. Deputy matron roles had been introduced to develop staff in leadership skills for the future.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve or a strategy to turn

this into action, developed with all relevant stakeholders. The vision and strategy were dependent on progress in regional developments within the wider health economy. However, leaders and staff understood the trust's vision and strategy and knew how to apply this in monitoring progress.

Senior leaders of the service had not identified a strategy for children and young people's services. We were told that development of a local strategy was dependent on progress in system-wide strategy, and this was being awaited. However, service leaders were working together with system partners in development of regional approaches. This focussed on development of integrated care pathways for children and young people, across the different regional service providers. Additional areas of focus included reviewing high dependency unit care, front door services and avoiding hospital admissions, including community resourcing. As part of systemwide working service leaders were also undertaking an options appraisal with a neighbouring NHS trust. This aimed at reviewing sustainability of services at other trusts, and the impact of this on local provision for children and young people.

The trust promoted a vison and a set of values which were used in communications to the public and members of staff across the trust. The trust's values were 'we care, we respect, we listen'

Staff we spoke with could readily identify the trust values and said these were meaningful and relevant to the work of the service. We saw during inspection that staff routinely demonstrated behaviours which were in accordance with the trust values.

Culture

Staff felt respected, supported and valued, although we also heard some concerns in the service. Staff were focussed on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were focussed on the needs of children and neonates, but staff also told us there were elements of a mixed culture in the service. Staff were seen working hard to prioritise safe care; however due to patient numbers and staff shortages, we saw staff were visibly under strain at times during the inspection. A range of staff raised concerns with us, particularly with regard to the challenges of meeting the needs of children and young people who were acutely unwell, with both physical illnesses and mental health needs. Frequently staff described their concerns about not feeling equipped to deal with the higher level care needs of some of their patients. Although staff told us they felt their managers were supportive, there was an underlying anxiety about the pressures of working in the service which appeared to be shared by many nursing staff. We also heard that the anxieties of facing these working pressures had on occasions contributed to staff absence, further compounding the staffing issues.

Nurse managers described changes in the neonatal service over the past eighteen months and the impact of this on staff morale. Although there had been some earlier challenges, managers described staff as now being proactively engaged in developments. We did hear of isolated comments and concerns from some staff on the unit, however we saw overall that morale among neonatal nurses was positive.

Medical staff in the service described being well supported, with good access to senior doctors and consultants when the need arose. Junior doctors on the children's ward described having a 'family-friendly' rota, with four off-duty requests in a month's rota. We heard that two registrars were returning to the trust for a second placement allocation.

Leaders expressed how proud they were of staff and described excellent teamworking in the service. Leaders felt there was no hierarchy in the service and that they were available for staff

when this was needed. We saw during inspection that senior leaders of the service were present to support staff facing different challenges on the children's ward. Managers felt they could approach senior leaders with their requests as they needed to; they felt they had support of senior leaders when this was needed.

Governance

Although the service had governance structures and processes were followed, there was a lack of robust oversight in key areas. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service.

Service leaders participated in the trust's committee reporting processes for management of clinical quality and patient safety, attending the monthly quality governance meetings of women's, children, young people's and diagnostics business group. Service performance, risks and audit outcomes were monitored on a regular basis, with action plans identified and progress monitored. The business unit's quality governance and risk committee reported in to the trust's quality governance and safety committees, and from here, reporting to the trust board for assurance. We saw however there was a lack of monitoring, or actions identified to provide assurance of safe care and treatment. Actions were not identified to improve safeguarding and mandatory training compliance, learning from incidents and to provide assurance of safe care for children and young people admitted with mental health needs.

Service leaders attended monthly paediatric mortality review meetings to identify any learning to be shared. A consultant-led paediatric audit meeting was held on alternate months, also attended by the multidisciplinary team.

Senior nurse leaders were visible in the service and met weekly to review and discuss any issues regarding the safety and quality of the service. In practice, daily communications were shared for any immediate feedback to the children's ward and outpatient department, and neonatal unit. The business unit also had processes in place to escalate any areas of concern as they arose to the trust's executive leaders.

Management of risk, issues and performance

Leaders and teams used systems to identify risks. However key risks and actions to reduce the impact of risks were not always progressed.

Senior nursing staff attended a monthly risk meeting in the women's, children's and diagnostics business unit. Service leaders reviewed any new risks in reviewing safeguarding and mandatory training compliance, and incidents resulting in harm. Risks were rated using a scoring matrix; any risks which scored above15 would be escalated to trust board.

At the time of the inspection, the highest risk identified in the service was for children and young people with mental health needs, under care of the children's service and the provider of mental health services. Although the risk register identified this as a high risk, the service had not completed a ligature-free environmental risk assessment for the children's ward, identifying associated mitigating actions. We raised this concern to the trust for immediate action during the inspection. Following inspection the trust provided evidence and assurance of their actions in response to this.

The service identified staffing shortages as a risk, with mitigation identified in planned recruitment. Although we frequently heard of challenges in skill mix across the service, with retirement and departure of experienced staff, this was only highlighted in the risk register for the neonatal unit.

The service noted equipment as a risk with regard to a rolling programme of equipment being replaced.

We did not see any reference to low levels of completion of safeguarding children level three training in identifying risks, nor the low compliance with some modules of mandatory training for medical and nursing staff in the service.

Information Management

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

Service leaders and managers had access to a range of service data, providing a picture of overall service activity, and allowing an understanding of where there may be challenges and further opportunities to develop. Leaders reviewed performance data when making any decisions about the service.

Computer terminals with intranet and internet access were available throughout the service and there were sufficient numbers of computers for staff to access information.

We saw there were standardised quality information boards on both the neonatal unit and children's ward which provided current quality data, such as staffing levels and safety performance.

There were clear display boards on main corridors within each unit containing patient feedback for staff, patients and carers to see.

Engagement

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

Staff in different parts of the service were involved in a variety of different engagement activities. Staff on the neonatal unit had introduced a competency passport and training for parents as part of a family integrated care approach. Competency passports provided parents with a record of their different neonatal skills in caring for their baby, including hygiene; developmental care; feeding; administering medicines; and preparing for home. Parents were supported to learn and develop their skills for caring for their baby, empowering them as partners in care.

Neonatal nurses ran a parent group for parents of babies discharged from the unit. Password access was provided to parents for a social media page, advertising monthly parent meetings at local venues. These activities had included 'messy play' for siblings, and 'pizza nights for dads'. The sessions were appreciated by parents and well supported. Additionally, a support group for parents under 25 years old was available.

Nursing staff on the neonatal unit and children's ward shared day-to-day communications in a private mobile phone messaging group.

Specialist children's nurses provided support to local schools when visiting children in these settings. Specialist nurses for paediatric diabetes had implemented a training package for Stockport schools, providing advice to education staff about diabetes management in children. This had been well received.

The trust had a staff recognition scheme, with staff receiving local awards. We saw the ward had received a 'recognition of excellence in practice' award from the associate director of nursing for

children’s services. The award had been given to staff for ‘going above and beyond, to provide the best possible care in very challenging and unprecedented times’. Staff told us this had been awarded for work during a time of high demand and staffing challenge in the service.

Staff returning to roles within the service and trust were invited to attend an informal meeting with the trust’s chief executive, 12 months following their return. Staff we spoke with described this as being to feedback on their experience and to note any changes or contrasts; staff described this as being an opportunity for an open and honest conversation.

Senior nursing staff participated in recruitment events at local universities and with national nursing organisations, to promote the trust and vacancies for potential nurse applicants.

Play specialists participated in a North West regional network of health play specialists, attending meetings four times a year and sharing learning and skills updates from this.

Service leaders had recently introduced a paediatric departmental newsletter, sharing updates of practice and learning.

Learning, continuous improvement and innovation

All staff were committed to learning and improving services. They had some limited understanding of quality improvement methods, and this was not embedded in practice. Leaders encouraged participation in research.

A paediatric research nurse was based in the children’s outpatient department. Research programmes currently included diabetes immunisation and meningitis B studies. One of the children’s nurses was awarded ‘Research Nurse of the Year’ at the Greater Manchester Clinical Research Awards in 2018.

Curriculum leaders from local universities visited the service to assess the suitability of the learning environment for student placements. During the inspection we saw a group of student nurses being provided with an induction to the children’s ward. Students said they had received good information in preparation for their placement.

Service leaders were developing work to reduce ‘avoidable admissions’, anticipating a pilot ‘virtual ward’ project launch in March 2020.