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Health and Adult Social Care Overview and Scrutiny Committee

Review of Care Quality Commission Inspection of East Cheshire NHS Trust December 2014

Date:	**Friday, 11th March, 2016**
Time:	**10.00 am**
Venue:	**Council Chamber - Town Hall, Macclesfield, SK10 1EA**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

3. **Declaration of Party Whip**

   To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the Agenda

4. **Public Speaking Time/Open Session**

For requests for further information
Contact: James Morley
Tel: 01270 686468
E-Mail: james.morley@cheshireeast.gov.uk with any apologies

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake and background research, it would be helpful if members of the public notified the Scrutiny Officer listed at the foot of the Agenda at least one working day before the meeting with brief details of the matter to be covered.

5. **Care Quality Commission Inspection of East Cheshire Trust Report May 2015** (Pages 1 - 30)

To consider the report published in May 2015 of the CQC into it's inspection of East Cheshire NHS Trust which took place in December 2014.

6. **East Cheshire NHS Trust response following CQC Report**

To consider a presentation from East Cheshire NHS Trust regarding the CQC's Inspection Report of May 2015 and how the Trust has responded to the actions recommended in the report.

(report to follow)

Agenda Item 5

East Cheshire NHS Trust

Quality Report

Macclesfield District General Hospital
Victoria Road
Macclesfield
Cheshire
SK10 3BL
Tel: 01625 421000
Website: www.eastcheshire.nhs.uk

Date of inspection visit: 9 - 12 December 2014
Date of publication: 15/05/2015

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected East Cheshire NHS Trust as part of our new comprehensive inspection programme.

We carried out an announced inspection of Macclesfield District General Hospital on 10, 11 and 12 December 2014. The announced inspection of community healthcare services also took place at this time and we carried out an announced inspection at Congleton War Memorial Hospital on 11 December 2014.

We undertook an unannounced inspection between 6am and 12.30pm on 22 December 2014 at Macclesfield District General Hospital only. During the unannounced inspection we looked at the management of medicines and checked to see what actions the trust had taken to address concerns we raised during the announced inspection in relation to children's and young people's services and surgical services.

Overall, we rated East Cheshire NHS Trust as 'requires improvement'. We have judged the service as 'good' for caring. We found that services were provided by dedicated, caring staff. Patients were treated with dignity and respect and were provided with appropriate emotional support. However, improvements were needed to ensure that services were safe, effective and responsive to people's needs, and we rated the trust as requires improvement with regard to services being well led.

Our key findings were as follows:

Incidents

- Systems were in place for reporting and managing incidents. However, these systems were not followed consistently across all services. Incidents were not always reported in line with trust policy, which meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in these services.
- In some services, there was poor understanding of the formal system for deciding the serious nature, or potential outcomes, of an incident or how it should be investigated. This meant that not all incidents with potential risks of harm were formally investigated or recorded or lessons shared.
- Some staff raised concerns that they were not given feedback on incidents that had been reported.

Safeguarding

- There was a clear policy in place that was accessible to staff on the intranet. However, there was a lack of clarity relating to the application of the policy.
- We found that there had been no self-referrals to adult social care in the last 18 months. We found that, when a potential safeguarding concern was identified, the incident would be investigated locally before being entered on the electronic reporting system. Only if the outcome of the investigation substantiated a safeguarding concern would it then be referred to adult social care. This was not in line with best practice.
- In addition, we were informed of an incident relating to the suspension of a member of staff for potential verbal abuse of a patient, which, on review, had not been reported via the safeguarding process.

Cleanliness and infection control

- During our inspection we identified concerns with the decontamination and storage of equipment and the maintenance of a safe environment. A number of areas showed signs of 'wear and tear' which meant that they could not be cleaned adequately. We raised our concerns immediately with the trust, which addressed the urgent issues.
- However, we were not satisfied that there were robust arrangements in place for monitoring the patient environment or for identifying and addressing risks in a timely manner. Policies for managing patients in isolation rooms were not always followed. Where risks had been identified, action had not always been taken in a timely way to protect patients from harm.
- We observed good practice in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment.

Medicines management

- The systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, were not robust or in line with requirements.

Summary of findings

- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.

Staffing

- Overall, medical treatment was delivered by sufficient numbers of skilled and committed medical staff.
- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.
- Consultant cover in critical care services was limited due to only six of the nine consultants being trained in intensive care. This meant that only 80% of patients were assessed by a consultant within 12 hours of admission to the critical care unit (CCU) and the provision of two daily ward rounds was not achieved at weekends.
- A shortfall in the number of junior doctors in urgent and emergency services meant that the trust had to employ locum staff from November 2014 to February 2015 to cover shortages. The trust was also having difficulty recruiting to four additional registrar posts. In addition, there were four vacancies for junior doctors in critical care services. Shortfalls were covered by locum, bank and agency staff.
- The trust was actively recruiting nursing staff from overseas to try to improve staffing levels. In most areas we found that nurse staffing levels were generally adequate at the time of our inspection. However, appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing staff working in adult community services to meet the needs of service users. Adult community teams experienced staff shortages and had difficulty in recruiting.
- We also found that nurse staffing levels within the children's unit were not always in line with Royal College of Nursing recommendations.
- The midwife-to-patient ratio averaged at one to 30. This was worse than the recommended number of one to 28. A staffing acuity guideline was in place based on Birth-rate plus. However this did not allow for this assessment to be done daily.

Mortality rates

- Our 'intelligent monitoring' report of July 2014 showed that there was no evidence of risk for summary hospital mortality level indicators or for hospital standardised mortality ratio indicators.

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and by the speech and language therapy team.
- The patient records we reviewed included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- Children and young people were offered a choice of meals that were age appropriate and supported individual needs, such as gluten-free and sugar-free. Children told us that they enjoyed the food. Parents told us that the food was good quality and there was a lot of choice, including healthy options.

We saw several areas of outstanding practice including the following:

- Care planning in the community dental service was found to be outstanding in its care planning and we observed excellent interactions with the diverse and complex needs of patients using the service.
- A learning disabilities and autism group was in place in the trust and the trust had received an Autism Access Award from the National Autistic Society.
- The trust's home intravenous therapy service had recently piloted new projects to expand the service into new specialities. For example, cardiology and alcohol management. The team had developed policies and procedures based on best practice from other trusts and in line with national guidance.
- The Parkinson's nurses, respiratory nurses, physiotherapists and podiatrists networked in specialist groups. They attended regular update meetings where some would present their work to peers outside the organisation.

We found evidence of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].The trust must take action to ensure improvements in these areas.

Summary of findings

Importantly, the trust must:

- Ensure that there are suitable arrangements in place to respond appropriately to any allegation of abuse in order to safeguard service users against the risk of abuse.
- Ensure that there are robust systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, in line with requirements.
- Ensure that there are effective processes in place for the decontamination and storage of clean and contaminated equipment and for the monitoring of this, particularly in relation to children's and young people's services.
- Ensure that the environment within the surgical wards and maternity services is well maintained and fit for purpose so that appropriate standards of cleanliness can be maintained.
- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced nursing and other staff working in adult community services to meet the needs of service users.
- Ensure that there are effective systems in place to identify, assess and monitor risks relating to the health, safety and welfare of both staff and the people who use services. This includes incident-reporting systems and risk management processes for the maintenance of equipment.
- Ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to children's and young people's services, community healthcare services for adults, pain relief documentation in the emergency department and 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to East Cheshire NHS Trust

East Cheshire NHS Trust provides a full range of acute and community services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery in most specialties, cancer services, paediatrics, maternity care and a range of outpatient services. Community health services include district nursing, health visiting, intermediate care, occupational therapy and physiotherapy, community dental services, speech and language therapy and end of life care.

Urgent and emergency services are provided across two sites: the emergency department at Macclesfield District General Hospital and the minor injuries unit (MIU) at Congleton War Memorial Hospital. Inpatient services are also provided from two sites: Macclesfield District General Hospital (the main site) and Congleton War Memorial Hospital (which runs an intermediate care service). Outpatient services are provided in Macclesfield District General Hospital and in community bases in Congleton, Handforth, Knutsford, Wilmslow and Poynton. In total, the trust has 376 beds.

Community health services are provided across East, Central and South Cheshire and Vale Royal.

East Cheshire NHS Trust is a non-foundation trust. NHS trusts are run slightly differently to foundation trusts. NHS foundation trusts, first introduced in April 2004, are independent legal entities and have unique governance arrangements. They are free from central government control and are no longer performance-managed by health authorities. As self-standing, self-governing organisations, NHS foundation trusts are free to determine their own future.

East Cheshire NHS Trust serves a population catchment area of approximately 450,000. Life expectancy for both men and women living in East Cheshire is better than the England average. However, local health profiles show that East Cheshire has three indicators for children and young people that are worse than expected: for smoking in pregnancy, starting breastfeeding and alcohol-specific hospital stays for those under 18 years old. Road injuries and deaths are also worse than expected in the East Cheshire area.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd, Bradford Hospitals NHS Foundation Trust.

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: eleven CQC inspectors; a head of governance; an NHS foundation trust executive director; a designated nurse for safeguarding children; a physician; a consultant in palliative care; a physiotherapist and outpatients locum specialist; a community paediatric physiotherapist and independent leadership consultant/mentor; a managing director; a consultant colorectal surgeon and medical director; a clinical director for women's services; a director of a school of community paediatrics and consultant paediatrician; an NHS leadership clinical fellow (previously an ST3 in the operative management of trauma); a nurse practitioner; a director of nursing in palliative care; a senior nurse and matron in theatres and a day care unit (band 8a); an emergency care technician and clinical supervisor; two experts by experience in outpatients and paediatrics; a matron in midwifery; a nurse consultant in critical care; a senior manager in paediatrics and child health, paediatrics, community services and sexual health; an advanced nurse practitioner/community matron specialist adviser; a school nurse; a health visitor; and an allied health professional.

Summary of findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

Before visiting, we reviewed a range of information we held about East Cheshire NHS Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

We held a listening event in Macclesfield on 9 December 2014 when people shared their views and experiences of services provided by East Cheshire NHS Trust. Some people also shared their experiences by email or telephone.

The announced inspection of Macclesfield District General Hospital took place on 10, 11 and 12 December 2014. The announced inspection of community healthcare services also took place at this time and we carried out an announced inspection at Congleton War Memorial Hospital on 11 December 2014.

We held focus groups and drop-in sessions with a range of staff at the trust including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas, outpatients services and community healthcare services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We undertook an unannounced inspection between 6am and 12.30pm on 22 December 2014 at Macclesfield District General Hospital only. During the unannounced inspection we looked at the management of medicines and checked to see what actions the trust had taken to address concerns we raised during the announced inspection in relation to children's and young people's services and surgical services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at East Chesire NHS Trust

What people who use the trust's services say

Family and Friends Test response rates were worse than the England average although the majority of responses indicated that most patients would be very likely or likely to recommend the trust as a place to have care and treatment.

The CQC inpatient survey was conducted between September 2013 and January 2014. A questionnaire was sent to 850 recent inpatients and responses were received from 395 patients. The trust was average when compared with similar trusts. It was noted that people rated 'being asked to give their views about the quality of the care they received in hospital' and 'information about complaints' at the lower end of the scale.

Summary of findings

Facts and data about this trust

East Cheshire NHS Trust serves a population catchment area of approximately 450,000. In total, the trust has 376 beds. In 2014, there were 36,839 admissions, 208,385 outpatients, 54,029 emergency department attendances and 5,415 attendances at the MIU based at Congleton War Memorial Hospital. The trust employs 3,200 members of staff. In 2013/14 the trust had a total income of £180,070 million.

The trust's infection rates for methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. difficile) and methicillin-sensitive Staphylococcus aureus (MSSA) were varied with no easily identifiable trends. The trust had five cases of MRSA and 20 cases of C. difficile between March 2013 and July 2014. Recent trust performance reports show that both MRSA and C. difficile monthly targets have been exceeded.

The trust reported that the main three reasons for delayed transfer of care were: waiting for further NHS non-acute care (accounting for 22.8% of delayed transfers, which was about the same as the England average); completion of assessment (21.5%, which was slightly worse than the England average of 18.7%); and patient or family choice (19.4%, which was worse than the England average of 13.8%).

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we have rated services at the trust as 'requires improvement' for safe. On our announced inspection of children's and young people's services at Macclesfield District General Hospital, we were not satisfied with the storage of breast milk and we observed contaminated equipment from elsewhere in the hospital stored inappropriately with clean equipment and clean baby cots. This presented a risk of cross-infection and harm. We were unclear about the decontamination arrangements for toys when there were staff shortages in the children's inpatient and outpatient areas. We identified that, due to a lack of available space, the decontamination of cots was difficult on the special care baby unit. We also found that staff were unclear regarding the decontamination arrangements for a breast pump. As a result the matron for the service asked the breastfeeding team to review the process The environment and layout in the children's ward were such that some parts of the unit were unobservable. There was no evidence of risk assessment when placing children and young people in these areas. We observed that patient acuity was such that the numbers of staff on shift were not in line with the Royal College of Nursing guidelines. We could not find evidence that patient acuity was assessed to ensure appropriate staffing levels. The issues were immediately brought to the attention of the senior team and the trust executive team. We reviewed these areas as part of our unannounced visit and were satisfied that the trust had put measures in place. Community nurses did not always report and investigate incidents in line with the trust's incident-reporting policy, which meant that there was the potential for under-reporting. Evidence of learning from incidents in the community nursing services was also limited. Community nursing teams used a dependency tool to determine whether caseload numbers were safe. However, it was difficult to assess whether caseloads were appropriate as the dependency assessment did not take into account the acuity of patients' needs on each caseload. We reviewed the dependency scores for nine teams for September and half of December, which came to a total of 42 days. We found that, during this period, the rating for 10 days had not been recorded, four days were rated green and the remaining 28	**Requires improvement** 

Summary of findings

days were rated either red or amber. This meant that there were potentially unsafe staffing levels for more than half the time during the period we reviewed. There was no evidence of any escalation or action taken.

The falls risk assessment and the end of life care pathway document were not always fully completed. This meant that records were not always completed or managed in a way that would keep people safe.

Duty of candour

- The duty of candour policy had recently been approved.

Safeguarding

- The trust risk register identified that not all staff had received level 2 safeguarding training. The risk had been identified on 26 July 2012. We were not satisfied that adequate actions were being taken to address this risk as levels of compliance with level 2 training varied across services and in some areas were below the required standard.
- The trust had a safeguarding team in place. This team was predominantly focused on children's safeguarding, with 17 out of the 19 team members based in children's safeguarding.
- There was a clear safeguarding policy in place that was accessible to staff on the intranet. However, there was a lack of clarity relating to the application of the policy.
- We found that there had been no self-referrals to adult social care in the last 18 months. We found that, when a potential safeguarding concern was identified, the incident would be investigated locally before being entered on the electronic reporting system. Only if the outcome of the investigation substantiated a safeguarding concern would it then be referred to adult social care. This was not in line with best practice.
- In addition, we were informed of an incident relating to the suspension of a member of staff for potential verbal abuse of a patient, which, on review, had not been reported via the safeguarding process.

Incidents

- Systems were in place for reporting and managing incidents. However, these systems were not followed consistently across all services. Incidents were not always reported in line with trust policy, which meant that data provided in relation to incidents may not provide a reliable oversight of incidents occurring in these services.

Summary of findings

- In some services, there was there was poor understanding of the formal system for deciding the serious nature, or potential outcomes, of an incident or how it should be investigated. This meant that not all incidents with potential risks of harm were formally investigated or recorded or lessons shared.

Infection control

- The trust's infection rates for MRSA, C. difficile and MSSA were varied with no easily identifiable trends.
- The trust had five cases of MRSA and 20 cases of C. difficile between March 2013 and July 2014. Recent trust performance reports show that both MRSA and C. difficile monthly targets have been exceeded.
- During our inspection we identified concerns with the decontamination and storage of equipment and the maintenance of a safe environment. A number of areas showed signs of 'wear and tear', which meant that they could not be cleaned adequately and patients were at risk of potential harm from cross-infection. We raised our concerns immediately with the trust, which addressed the urgent issues.
- On our announced inspection of children's and young people's services at Macclesfield District General Hospital we were not satisfied with the storage of breast milk and staff were unclear about the decontamination arrangements for a breast pump.
- In addition, we observed contaminated equipment from elsewhere in the hospital stored inappropriately with clean equipment and clean baby cots; this presented a risk of cross-infection and harm.
- We were unclear about the decontamination arrangements for toys when there were staff shortages in the children's inpatient and outpatient areas. We also identified that, due to a lack of available space, the decontamination of cots was difficult on the special care baby unit.
- These issues were immediately brought to the attention of the senior team and the trust executive team. We reviewed these areas as part of our unannounced visit and were satisfied that the trust had put measures in place.
- Policies for managing patients in isolation rooms were not always followed.
- We observed good practice in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment.
- We were not satisfied that there were robust arrangements in place for monitoring the patient environment or for identifying and addressing risks in a timely manner.

Staffing

Summary of findings

- Overall, medical treatment was delivered by sufficient numbers of skilled and committed medical staff.
- Consultant cover in critical care services was limited due to only six of the nine consultants being trained in intensive care. This meant that only 80% of patients were assessed by a consultant within 12 hours of admission to the CCU and the provision of two daily ward rounds was not achieved at weekends.
- A shortfall in the number of junior doctors in urgent and emergency services meant that the trust had to employ locum staff from November 2014 to February 2015 to cover shortages. The trust was also having difficulty recruiting to four additional registrar posts. In addition, there were four vacancies for junior doctors in critical care services. Shortfalls were covered by locum, bank and agency staff.
- The trust was actively recruiting nursing staff from overseas to try to improve staffing levels.
- In most areas we found that nurse staffing levels were generally adequate at the time of our inspection. However, appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing staff working in adult community services to meet the needs of service users. Adult community teams experienced staff shortages and had difficulty in recruiting.
- We also found that nurse staffing levels within the children's unit were not always in line with Royal College of Nursing recommendations.
- The midwife-to-patient ratio averaged at one to 30. This was higher than the recommended number of one to 28. A staffing acuity guideline was in place based on Birth-rate plus. However this did not allow for the assessment to be done daily.
- The trust had implemented a monthly risk-assessed data report (RADaR) to identify staffing hotspots and the impact on quality indicators. This was referenced by senior teams, but there was limited evidence of the report being understood or used at ward level.
- The trust board's safe staffing paper concentrated on inpatient areas and made no reference to community services or any assessment of nurse staffing levels.

Medicines management

- The systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, were not robust or in line with requirements.

Summary of findings

- Anticipatory prescribing in end of life care was common, in line with best practice. This meant that pain relief and other medication could be started quickly if patients became unwell.

Records

- The standard of record completion varied across the services. For example, we found gaps in the completion of records relating to medication, demographics and growth charts. There were also variations in the completeness of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms across the trust.
- In the community, the falls risk assessment and the end of life care pathway document was not always fully completed. This meant that patients were at risk of not received appropriate care. The falls template in use at the time of the inspection was based on national guidance. However community nurses told us they found these documents were cumbersome to use and felt they did not meet the needs of people in the community.
- Records were not always stored securely in line with requirements.

Equipment

- We found that equipment was not always checked or replaced in line with manufacturers' recommendations. During our inspection we raised this issue with the trust and the trust took immediate action to address our concerns. We were not satisfied that there were robust processes in place for the monitoring, maintenance and replacement of equipment in a timely manner.

Are services at this trust effective?

Requires improvement

The effectiveness of the services provided by the trust have been rated as 'requires improvement'.

Processes and procedures relating to the assessment of staff competence and confidence in using continuous positive airway pressure (CPAP) respiratory equipment within the children's unit were not robust and relied on self-assessment. Staff also raised concerns relating to their competence and confidence in supporting children and young people with mental health needs. This had been reflected on the local risk register since 2013. While the provision of suitable training was partly beyond the trust's control, it was unclear what the trust had done to mitigate this risk.

Summary of findings

In community children's services, data showed that only 50% of children received a review between the ages of two and two and a half. This demonstrated a reduced level of performance against expected standards as the child progressed from being an infant.

Community services for adults were unable to provide us with a clear overview of what their performance indicators were and what the outcomes were for patients. Podiatrists and physiotherapists told us that they were meeting their targets but did not have evidence of this. Staff had limited access to the trust's intelligence data or any information the trust gathered.

Training records showed that most community staff had completed mandatory training and appraisals within the last 12 months. However, a training record for one of the out-of-hours nursing teams showed that, out of 30 staff, only half had completed their mandatory training and only half had received an appraisal.

Consultant and specialist palliative care services were available but lacked clear lines of communication between them to provide an effective service. The specialist palliative care team (SPCT) was not always made aware of the consultant cover arrangements in place during periods of annual leave or absence or out of hours. The palliative care service was limited to weekdays only with only informal consultant cover provided during periods of absence.

The majority of community adult nursing staff had received training in the Mental Capacity Act and deprivation of liberty safeguards. However, several staff, including senior clinical staff, did not know what the term 'deprivation of liberty' meant or how to apply the Mental Capacity Act 2005 to their work. There were variations in completeness of DNA CPR forms across the trust.

In most services, care and treatment provided were evidence-based and adhered to national guidance. Services participated in national and local clinical audits.

Evidence-based care and treatment

- Staff were not always confident in the use of equipment.
- We saw evidence of patients receiving care according to national guidelines and there was participation in national audits.
- Clinical audits included the monitoring of guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons.

Patient outcomes

Summary of findings

- There was a reduced level of performance against expected standards in community children's services. Breastfeeding statistics were worse than the England average. The trust had identified this as an area for improvement and an action plan was in place.
- The Healthy Child Programme (HCP) data did not include the antenatal contact performance. Teams told us that they had been unable to make antenatal contact with some families due to a lack of capacity.
- Community services for adults were unable to provide us with a clear overview of what their performance indicators were or what the outcomes were for patients. Podiatrists and physiotherapists told us that they were meeting their targets but did not have evidence of this. Staff had limited access to the trust's intelligence data or any information the trust gathered.
- Patient-reported outcome measures (PROM) data for April 2013 to December 2013 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was either similar or better than the England average.
- Hospital episode statistics (HES) data for 2013/14 showed that the number of patients who underwent elective and non-elective surgery and were readmitted to hospital following discharge was lower (better) than the England average for all specialties except elective ophthalmology.
- The lung cancer audit for 2012 showed that the trust performed better than the national average for both the number of cases discussed at multidisciplinary team meetings (100% compared with the England and Wales average of 95.6%) and the percentage of patients receiving computerised tomography (CT) scans before bronchoscopy (95.4% compared with the England and Wales average of 89.5%).
- The trust's mortality rates were in line with the expected range as measured by the hospital standardised mortality ratio.

Multidisciplinary working

- There was good evidence of multidisciplinary working in most areas, although lines of communication were not always clear. This was evident in end of life care.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- In the main, staff had a good understanding of trust policies and procedures relating to consent. Staff also understood the implications of the Mental Capacity Act 2005 and deprivation of liberty safeguards (DoLS).

Summary of findings

- The majority of community nursing staff had received training in the Mental Capacity Act 2005 and DoLS. However, several staff, including senior clinical staff, did not know what the term 'deprivation of liberty' meant or how to apply the Mental Capacity Act 2005 to their work.
- Staff were aware of consent procedures in place for children and young people. Staff were aware of the underpinning principles relating to Gillick competencies for deciding whether a child was mature enough to make decisions and give consent.
- In end of life care, we found that there were variations in the completeness of DNA CPR forms across the hospital. Forms were supposed to be reviewed daily but evidence suggested that this did not happen consistently.

Are services at this trust caring?

Good

The services at the trust have been rated as 'good' for caring.

In all areas inspected, staff treated patients with dignity, compassion and respect, even while working under pressure. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. Staff provided patients and their families with emotional support and comforted patients who were anxious.

The Friends and Family Test scores were positive. Staff confirmed that they could access management support or counselling services if they had been involved in a traumatic or distressing event and debriefs were held following such events.

Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs and there were bereavement services in place to provide support for patients, relatives and staff.

Young people were included and involved in decision making; we were assured that this was the case through our observations and by speaking with young people and their families. Children, young people and their families told us: "Staff are fantastic."

Compassionate care

- Care was observed to be kind and compassionate.
- Staff treated patients with dignity, compassion respect and empathy even while working under pressure.
- Patients spoke positively about the care and treatment they had received and we observed many positive interactions.

Summary of findings

- Staff from all services were committed to providing good quality care.

Understanding and involvement of patients and those close to them

- Staff were kind and polite in their interactions with patients and their families.
- Patients told us that they were involved in planning their care.

Emotional support

- Staff provided patients and their families with emotional support and comforted patients who were anxious.
- Care planning within community dental services was found to be outstanding and we observed excellent interactions with the diverse and complex needs of patients using the service.

Are services at this trust responsive?

Requires improvement

The services at the trust have been rated as 'requiring improvement' for responsiveness.

Patients experienced delayed transfers of care to other providers, such as community intermediate care or nursing homes.

The hip fracture audit for 2013 showed that the hospital's performance was worse than the England average for the percentage of patients undergoing hip surgery within 36 hours The surgical services met the national targets for 18-week referral-to-treatment time (RTT) for patients admitted for general surgery but failed to meet the national targets for all other specialties. The theatres department did not always meet its own performance targets, which meant that theatre lists did not always start or finish at the required times. All patients whose operations were cancelled were treated within 28 days.

Overall, the trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival at accident and emergency (A&E) between 5 January 2014 and 28 September 2014. However, we found discrepancies in the recording of waiting times at the MIU. Waiting times were recorded only from when the nurse actually saw and treated the patient to when the patient was discharged. This meant that data did not provide an accurate picture of the waiting times for this service. Overall, however, this had a limited impact on the trust's waiting time targets. Patient flow out of the emergency department was a challenge and had a negative impact on the time patients spent waiting within the department.

Summary of findings

Due to the lack of available outpatient clinic rooms in children's services, an area on the inpatient unit was utilised to support clinics. Staff told us that this happened frequently due to the challenges posed by the number of clinics running and the space available.Staff told us that the children's ward environment was not conducive to meeting the needs of children and young people with mental health needs.

The organisation of the outpatients department was not always responsive to patients' needs. Nearly a third of clinics were cancelled and patients experienced delays when waiting for their appointments.

Complaints procedures and details of how to complain were visible and available across children's and young people's services, including information in a child-friendly format. Translation services were available and staff knew how to access them. We found evidence of multidisciplinary case conferences and discharge planning to support children's individual needs.

Cancer waiting times were consistently better than the England average for 31-day and 62-day targets. Since September 2013, RTT for patients with incomplete pathways had been better than the England average. RTT for non-admitted patients had been inconsistent between April 2013 and May 2014 but times had been better than the England average since June 2014. Diagnostic waiting times had been better than the England average since November 2013.

Service planning and delivery to meet the needs of local people

- The surgical services met the national targets for 18-week RTT for patients admitted for general surgery but failed to meet the national targets for all other specialties.
- A high number of gynaecology operations were cancelled at short notice.
- There were high levels of outpatient clinic cancellations and patients experienced delays when waiting for their appointments.
- Within end of life care services, there was evidence to show that most people received care in their place of choice.

Meeting people's individual needs

- There were good examples of services being organised to meet people's needs, particularly patients with a learning disability.
- The trust had received an Access Award from the National Autistic Society.

Summary of findings

- Translation services were available for patients where English was not their first language, although staff told us that this took 24 hours to arrange.
- The process to provide appropriate equipment for bariatric patients was not timely.

Access and flow

- The trust had met the national Department of Health target to admit or discharge 95% of patients within four hours of arrival at A&E between 5 January 2014 and 28 September 2014. Patient flow out of the department was a challenge and had a negative impact on the time patients spent waiting within the emergency department.
- There were high levels of bed occupancy and poor patient flow in the trust. Bed occupancy had regularly exceeded 85% in the previous year.
- Patients experienced delayed transfers of care to other providers, such as community intermediate care or nursing homes.
- There was little evidence of integrated working across community and acute settings, except in respiratory services.

Learning from complaints and concerns

- Complaints procedures and details of how to complain were visible and available across the areas we visited. The Patient Advice and Liaison Service (PALS) was very proactive.
- Processes in place to learn effectively from complaints were variable.
- However, a 'Learning into practice' newsletter for staff had been launched in November 2014 to promote lessons learned from complaints and incidents.

Are services at this trust well-led?

Requires improvement

The services at the trust have been rated as 'requires improvement' for being well led.

The vision and strategy for the trust and services were not always clear. The trust lacked a clear strategy that encompassed the delivery of financial targets and full integration of community services.

There was a governance system in place that allowed risks to be escalated to the trust board. In most cases there were action plans in place to address the identified risks. However, we found that, when issues were identified, timely action was not always taken to address those risks and there was a disconnect between departmental risk registers and the corporate risk register.

Summary of findings

Some staff told us that they had been in post for only a limited amount of time and this had impacted on their ability to progress actions (for example: “I have only been in post 18 months”). This meant that there was a lack of pace evident in the progressing of actions.

Staff felt that managers were approachable and supportive of staff. However, there had been a review of leadership roles and we were told by staff that, as a result of these changes, leaders were less visible and support had decreased. The new structure was still in the process of being embedded within the organisation. A15-month development programme for leaders had been established to support this. This had commenced in September 2014.

Not all staff groups felt that the trust board was visible; this was particularly evident in community services.

Vision and strategy

- The trust lacked a clear strategy that encompassed the delivery of financial targets and full integration of community services.
- The trust had a number of single-handed specialties, including clinical haematology, stroke, diabetes and oral surgery. The trust recognised that sustainability of delivery would require the development of a collaborative partnership model.
- The vision and strategy for services were not always clear. For example, the trust’s 2013/14 quality strategy identified improving access to outpatient services as a key priority for 2014/15, but staff were not aware of any significant plans in place to achieve this.

Governance, risk management and quality measurement

- A quality strategy had been in place in the trust since 2012. This strategy was in the process of being refreshed.
- There was a dashboard showing high-level performance and quality indicators for trust services. This was reported to the trust board.
- The trust had implemented a monthly RADaR to identify staffing hotspots and their impact on nurse-sensitive quality indicators. This was referenced by senior teams, but there was very limited awareness of this among the staff members we spoke with at ward level.
- A duty of candour policy had recently been approved.
- It was not clear how the board was informed of serious incidents. The trust board and safety, quality and standards (SQS) committee minutes did not include details of discussions that would have provided evidence of robust challenge.

Summary of findings

- There was a system in place that allowed risks to be escalated to the trust board. In most cases, there were action plans in place to address the identified risks. However, we found that, when issues were identified, timely action was not always taken to address those risks and there was a disconnect between departmental risk registers and the corporate risk register.
- There was no evidence of a comprehensive equipment replacement programme being in place.
- The corporate risk register had more than 90 risks identified. It was not clear how robustly these were reviewed by the trust board, as minutes did not include details of discussions that would have provided evidence of robust challenge.
- The response to complaints was poor: only 60% of complaints had been responded to within the target timeframe at the time of the inspection. The trust board was aware of the fall in complaint response times. A performance improvement plan was place to address this.
- PALS was well regarded by staff and was proactive in attending wards and departments on a regular basis. However, at the time of our inspection, the service was co-located with the complaints team; this was not in line with the recommendations contained in the Clwyd and Hart report A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture.
- There were no processes in place for monitoring or reporting the lack of tertiary capacity within children's services should a higher level care bed be required and not available in a receiving organisation. We were informed that such a situation would be reported only if care were compromised or unsafe. This meant that the health community was potentially unaware of the level of demand and capacity requirements within these services.

Leadership of the trust

- In the main, the trust board and executive members were well established and therefore afforded extensive organisational memory. The exception to this was the director of finance, who had taken up their post in January 2014, and the medical director, who was a recent interim appointment following a failure to recruit to the substantive post. The chief operating officer and chief nurse was an amalgamated role.
- Visibility of the executive team was variable. The chief executive was widely known throughout the trust. However, there was a disconnect between the trust board and staff providing community services; staff did not know who the board members were and felt that they were not visible.

Summary of findings

- Staff reported that they received good support from their line managers and team leaders. However, staff working in community services were unclear about the management structure above their immediate line manager.
- There was a lack of clarity regarding professional lines of accountability among community nursing teams. This could not be clarified at the time of the inspection.
- The trust board's regular monthly safe staffing paper made no reference to community services or to the assessment of nurse staffing levels within community services. We saw evidence from the District Nursing Action Plan 2014–2015 that the trust planned to review the staffing for community nursing and their skill mix, to review the mobile working project and to improve communication links with senior management. The staff we spoke with within community services were unaware of the actions being taken. There was limited evidence of progress with the action plan.
- Team briefings were made available to staff on a monthly basis. However, staff informed us that they often found the information circulated lengthy and confusing.
- We were not satisfied that there were robust professional arrangements in place for monitoring the patient environment or for identifying and addressing risks in a timely manner.
- Understanding of Safeguarding, Deprivation of Liberty, and the Mental Capacity Act 2005 (MCA) was limited in some areas, particularly in community adult healthcare services. In that staff did not understand the requirements of the MCA. This meant that patients did not always benefit from a service which reflected their best interests and concerns were not always reported via the safeguarding process.

Culture within the trust

- Most staff we spoke to were friendly, welcoming and positive about working in the trust.
- A survey completed by the General Medical Council regarding the National Training Scheme showed that doctors' training needs were met within expectations. For example, doctors felt that they received adequate clinical supervision, induction and local teaching.
- The trust had a well-developed set of values and behaviours that were largely recognised by the front-line teams.

Fit and proper persons

- There was an awareness amongst most of the executive team of the need to have in place 'fit and proper person' checks. However there was no evidence that the trust was complying

Summary of findings

with this requirement at the time of the inspection. This was planned to be included in a board development session in January. This is covered by Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014, which ensures that directors of NHS providers are fit and proper to carry out this important role.

Public and staff engagement

- Patient feedback was obtained through routine patient experience surveys. Data for July 2014 to September 2014 showed that the majority of patients responded positively in relation to their involvement in care and treatment and with regard to whether staff treated them with dignity and respect.
- The trust had recently developed a patient experience strategy that described an organisational approach called 'Patients First'. This was aimed at involving service users in developing and improving services, but it was too soon to establish its impact at the time of the inspection.

Innovation, improvement and sustainability

- Ward staff spoke positively about the use of electronic handheld devices for monitoring patient observations.
- The trust also planned to introduce electronic patient records across all its services; this project was in its early stages at the time of our inspection.

Overview of ratings

Our ratings for Macclesfield District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for community services at this trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Community health inpatient services	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community dental services	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Overview of ratings

Our ratings for East Cheshire NHS Trust

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

Notes

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice, including the following:

- A learning disabilities and autism group is in place in the trust and the trust has received an Autism Access Award from the National Autistic Society.
- Care planning in the community dental service was found to be outstanding and we observed excellent interactions with the diverse and complex needs of patients using the service.
- Maternity services had received no complaints in the past 12 months. They were the only service in the trust to have this record.
- The community dental service ran an oral hygiene education programme that fed into national data to improve children's oral health nationally.
- Hebden Green Community School had implemented a model of shared leadership between the head teacher, the lead therapist and lead nurse to ensure that the needs of the child were central, with the aim of keeping children in school to improve individual outcomes.
- School nurses at Eaglebridge Clinic in Crewe had developed a duty nurse rota to access and respond to all enquiries on a daily basis on behalf of the team. This ensured that prompt, responsive care could be provided.
- Eaglebridge Clinic school nurses also had a weekly allocation meeting to ensure that all safeguarding commitments were covered by the team, ensuring consistency where possible.
- The home intravenous therapy service had been established for several years. National evidence illustrates the benefits of community-led intravenous services, which facilitate a patient's early discharge from hospital to a community setting, and, where appropriate, eliminates the need for admission into hospital. The service had recently piloted new projects to expand the service into new specialities. For example, cardiology and alcohol management.
- The Parkinson's nurses, respiratory nurses, physiotherapists and podiatrists networked in specialist groups. They attended regular update meetings where some would present their work to peers outside the organisation.
- Pain relief for patients receiving palliative care was discussed at multidisciplinary meetings and plans were made for patients' pain control. Anticipatory prescribing was common, in line with best practice, so that pain relief and other medication could be started quickly if a patient became unwell.
- Adult community services planned and coordinated care packages for patients who needed integrated teams to provide support at home. For example, we saw patients being supported by the community nurse, occupational therapy and social services.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

The trust must:

- Ensure that there are suitable arrangements in place to respond appropriately to any allegation of abuse in order to safeguard service users against the risk of abuse.
- Ensure that there are robust systems in place for the management, storage, administration, disposal and recording of medication, including controlled drugs and oxygen, in line with requirements.
- Ensure that there are effective processes in place for the decontamination and storage of clean and contaminated equipment and for the monitoring of this, particularly in relation to children's and young people's services.

Outstanding practice and areas for improvement

- Ensure that the environment within the surgical wards and maternity services is well maintained and fit for purpose so that appropriate standards of cleanliness can be maintained.
- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced nursing and other staff working in adult community services to meet the needs of service users.
- Ensure that there are effective systems in place to identify, assess and monitor risks relating to the health, safety and welfare of both staff and the people who use services. This includes incident-reporting systems and risk management processes for the maintenance of equipment.
- Ensure that records contain accurate information in respect of each patient and include appropriate information in relation to the treatment and care provided, particularly with regard to children's and young people's services, community healthcare services for adults, pain relief documentation in the emergency department and 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who use services and others were not protected against the risks associated with the unsafe management and storage of medicines. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010: Management of medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The provider did not operate effective systems designed to prevent and control the spread of infection and did not maintain appropriate standards of cleanliness and hygiene in relation to equipment. Regulation 12(2)(a)(c) HSCA 2008 (Regulated Activities) Regulations 2010: Cleanliness and infection control.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider did not operate effective systems to identify, assess or monitor risks relating to the health, safety and welfare of people who use services and staff. This included incident-reporting systems and risk management processes for the maintenance of equipment. There were no quality measures or key performance indicators for community services. This meant that the

This section is primarily information for the provider

Compliance actions

trust did not have robust oversight of the quality of services provided. Regulation 10(1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were insufficient numbers of staff to meet the needs of people and keep people safe. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and other staff working in adult community services to meet the needs of service users. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The provider did not have suitable arrangements in place to respond appropriately to any allegation of abuse in order to safeguard service users against the risk of abuse. Safeguarding concerns were not reported to the local safeguarding authority in line with best practice requirements. Regulation 11(1)(b) HSCA 2008 (Regulated Activities) Regulations 2010: Safeguarding people who use services from abuse.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: Service users were not protected against the risks arising from a lack of proper information about them. The provider did not

This section is primarily information for the provider

Compliance actions

maintain an accurate record in respect of each service user including appropriate information and documents in relation to the care and treatment provided. The provider did not ensure records were kept securely, particularly in children's and young people's services. Regulation 20 (1) (a) (2) (c) HSCA 2008 (Regulated Activities) Regulations 2010: Records

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