Review of compliance

Peterborough and Stamford Hospitals NHS Foundation Trust Peterborough City Hospital	
Region:	East
Location address:	Bretton Gate Peterborough Cambridgeshire PE3 9GZ
Type of service:	Acute Healthcare
Date the review was completed:	January 2011
Overview of the service:	Peterborough and Stamford NHS Foundation Trust provides a range of hospital-based acute healthcare services to people across Peterborough, North and East Cambridgeshire, South Lincolnshire, West Norfolk, East Northamptonshire, East Leicestershire and Rutland. Currently over 3000 staff provide the service from two locations. This review was conducted to look at emergency care services operating from

	Peterborough City Hospital. This hospital was registered with CQC in November 2010 and currently has no conditions on its registration.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Peterborough City Hospital was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Meeting nutritional needs
- Cooperating with other providers
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Staffing
- Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 December 2010, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

During our visit to the emergency department on 21 December 2010, we spoke with a large number of people who were using the service and also spoke with their relatives.

People told us that overall they felt that the facilities were better than those offered at the previous A&E department located at Peterborough District Hospital. However, a number of people felt that the parking arrangements were not adequate and that the emergency department's waiting room was very cold.

The majority of people spoke highly of clinical staff and the treatment they received. People told us that they had been given specific information regarding their condition and details of discharge arrangements. People told us that their nutritional needs were met where applicable and that they were offered timely pain relief.

Although the emergency department was not excessively busy on the day of our visit, a number of people who had attended on previous days had experienced very long waits for treatment.

People told us that they found the booking in and triage arrangements confusing, and that signage in and around the department was not sufficient. People we spoke with also told us that they had been required to discuss private information in a public area.

What we found about the standards we reviewed and how well Peterborough City Hospital was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found confusion regarding booking in and triage arrangements and that people did not feel the process was effective or allows sufficient privacy.

We found that there is insufficient information available for people regarding the service, types of injuries or waiting times. This is particularly relevant to people whose first language is not English.

Overall, we found that improvements are needed for this essential standard.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

Some people have been experiencing unacceptable waits for treatment in the emergency department since its relocation in early December 2010. The trust has adopted a range of measures to identify, consider and resolve these issues. Initiatives have included: working with partner agencies to resolve discharge problems and capacity risks, using a range of internal processes to review bed capacity and resolve discharge problems on a frequent basis, and the redeployment of additional staff across the emergency department and within other key services. While there is no evidence that this situation has caused immediate risks to patients we were told that this has caused inconvenience in some circumstances.

Overall, we found that improvements are needed for this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

There are systems in place within the emergency department to assess and meet people's hydration and nutrition needs. There is easy access to drinks and snacks for people waiting to be seen.

Overall, we found that Peterborough City Hospital was meeting this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services

We found a number of issues that indicate that the trust's partner agencies are not fully aware of the emergency department's referral and treatment criteria. These include: people that had been referred by their GPs where the emergency department had not been forewarned; people that had been re-referred on to the emergency department by the local walk-in service, due to long waits within the initial service; and a number of inappropriate referrals to the emergency department.

Some people have been experiencing unacceptable waits for treatment in the emergency department since its relocation in early December 2010. Ambulance staff have also experienced delays in being able to handover people to emergency department staff. While the trust has adopted a range of measures to identify, consider and resolve these issues, and there is no evidence that this situation has caused immediate risks to people, we were advised that this has caused inconvenience to people and resource issues for the ambulance services.

Overall, we found that improvements are needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

There is insufficient signage both within and outside the department to ensure people are clear regarding arrangements and facilities.

Car parking arrangements are unclear. This is particularly relevant to people with disabilities and to those dropping people off in an emergency.

We found examples of where security is inadequate and where the storage of equipment is unsafe.

Problems were found with doors, which meant a cold environment in some areas and difficulties in accessing the short stay area.

Overall, we found that improvements are needed for this essential standard.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

The trust uses a voice activated communication system in addition to other means of communication. While this is highly valued by staff, we were told that this does not always work adequately.

Ambulance staff told us that they had found some difficulty in accessing medical equipment and gases within the emergency department.

Overall, we found that Peterborough City Hospital was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The trust had systems in place to assess and monitor emergency department staffing levels and had increased staff in line with their findings.

Overall, we found that Peterborough City Hospital was meeting this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

We found that individual records were not being stored securely. This does not meet the requirements of the Data Protection Act 1998 or guidance from the Department of Health regarding records management.

Overall, we found that improvements are needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with a large number of people using the emergency department and their relatives during our visit on 21 December 2010.

The majority of people said that they felt that staff gave them information to enable them to understand their treatment and make informed decisions.

While the majority of people and relatives spoke highly of clinical staff, some other people did advise of situations where clinical staff had not respected their dignity. One person gave an example of where a nursing staff member had been abrupt whilst another person gave an example of a lack of privacy when other people had been brought into her child's cubicle.

A large number of people told us of their experience of the booking in and triage system and how they felt this did not meet their needs. People told us about long queues to book in and that, on occasions, it appeared that reception staff were completing other tasks rather than booking people in. Some people told us of

difficulties in being heard by or hearing reception staff, which they felt was due to the design of the partition screen. A number of people felt that they were being asked to supply very personal details within a public space. Many people said that they were ‘very confused’ regarding the booking in process and which queue they needed to join first.

Some people for whom English is not a first language had observed that there is no information available in other languages.

A number of people said they were not informed of waiting times.

Other evidence
We observed that, although the emergency department was not excessively busy, there were at times very long queues for people or their relatives to book in. We observed occasions when the reception desk was not staffed and occasions when reception staff appeared to be completing clerical tasks rather than booking people in. We did note that people were confused about where they needed to book in. Currently, triage is being undertaken from a desk within the main waiting area that is intended for security personnel. We observed that people were being asked for personal details within hearing of other people and security personnel.

A dry wipe board is located adjacent to the triage desk in the waiting area for the recording of estimated waiting times. At one point during the visit we noted that this did not include details of waiting times. At a later point during the visit we noted that this stated waiting times to be at 3 hours, however staff confirmed to us that this was incorrect.

Within clinical areas we observed staff working with people and their relatives. Staff were courteous and did attempt to protect people's dignity: the majority of people with whom we spoke agreed with this observation.

We noted that there was only one information leaflet available in a language other than English, this was a head injuries advice sheet available in Polish.
Staff advised that the majority of information leaflets are available in the main languages spoken in Peterborough, however, these had not been displayed since the move to the new hospital. Staff were unable to locate the leaflets before we left. Staff advised about translation services available to assist them in talking with people, which they had found helpful. In addition, they also had access to a communication aid that includes translation of key phrases in 15 languages and pictures to assist when communicating with people who have literacy needs.

Our judgement
Overall we found that improvements are needed for the trust to achieve compliance with this essential outcome.

We found confusion regarding booking in and triage arrangements and that people did not feel the process was effective or allows sufficient privacy.

We found that there is insufficient information available for people regarding the service, types of injuries or waiting times. This is particularly relevant to people whose first language is not English.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with a large number of people and their relatives during the visit on 21 December 2010.

On the day of the visit, the emergency department was not excessively busy. The majority of people, or their relatives, told us that they had experienced reasonable waiting times to receive treatment. In contrast, people had attended the emergency department on previous days and they told us they had experienced long waiting times on these occasions. One person advised us of a long wait for discharge: this appeared to have been caused by a delay in receiving medication from the pharmacy.

A number of people confirmed to us that they had been offered pain management following triage and throughout their treatment.

Generally, people and their relatives told us that they felt the care they had received from clinical staff was good and that they had been given time to understand their condition and discuss treatment options.

The majority of people with whom we spoke were happy with discharge arrangements. However, we spoke with two people who had previously attended the department and had not been satisfied. One person had been fully discharged but

had later received a request to re-attend the emergency department.

Other evidence

We discussed waiting times with the trust's management team. They confirmed that there had been some days earlier in December 2010 where waiting times in the emergency department had been unacceptable. An audit of information showed a daily increase in patients attending the service since its opening in early December 2010. The trust confirmed that in part this was due to a range of winter pressures, including high levels of patients attending with flu like symptoms, weather related injuries and Norovirus. The audit provided evidence that the numbers attending were significantly higher than those attending the previous A&E department during the same period in 2009.

We were also informed that the trust has also experienced high levels of staff sickness and that this had resulted in heavy reliance on agency staff and staff from other departments. Staffing attendance records and planned rotas for the period 12 to 25 December 2010 indicated that usage of temporary staff had ensured that staffing was in line with regular numbers. There were acceptable levels of staff with A&E experience available at all times.

We were advised by the management team about other pressures that had created a backlog of patients in the emergency department on some occasions. This had included delayed discharge in the main hospital impacting on movement from the short stay ward in the department, as well as the closure of beds within the City Care Centre due to Norovirus. During our visit the trust received notice from the Primary Care Trust that a number of beds had become available, allowing for move on.

Four ambulance staff told us that since the emergency department had opened there had been occasions where there had been long waits to hand patients over to the hospital. One of the ambulance staff had experienced a delay of two hours on one day, which in turn had impacted on the ambulance service's capacity to attend other calls.

We were advised of measures that the trust had put in place to alleviate long waiting times, including the redefinition of the emergency pathway to include acute admissions. The trust has also begun daily capacity meetings to look at bed management issues, hourly reviews of emergency and short stay bed numbers and waiting times, the deployment of additional nursing and medical staff, and additional management to support staff. Pharmacy availability had been reprioritised to aid speedier discharge on key wards. The trust has commissioned an external consultant to review and provide expert advice on redeveloping the emergency pathway.

At the time of our visit the emergency department was not excessively busy and none of the people we spoke with were found to have waited longer than the Department of Health four hour target that is currently in place.

A bed capacity meeting took place during our visit, which was well attended by staff from a range of the hospital services. There was discussion regarding potential bed problems and how possible blockages could be alleviated. At this meeting, it was

confirmed that there had been one person that day whose attendance time had been longer than four hours.

A copy of the assessment form used by emergency department staff included a number of prompts to check individuals' pain level at various stages of their assessment and treatment. Individual completed assessment records included details of pain assessments.

Our judgement
Overall, we found that improvements are needed for the trust to achieve compliance with this essential outcome.

Some people have been experiencing unacceptable waits for treatment in the emergency department since its relocation in early December 2010. The trust has adopted a range of measures to identify, consider and resolve these issues. Initiatives have included working with partner agencies to resolve discharge problems and capacity risks, a range of internal processes to review bed capacity and resolve discharge problems on a frequent basis, and the redeployment of additional staff across the emergency department and within other key services.

While there is no evidence that this situation has caused immediate risks to patients, we were told that this has caused inconvenience in some circumstances.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We spoke with a large number of people and their relatives during the visit.

None of the people that we spoke with had specific medical dietary requirements or had required food during their time within the emergency department.

One relative informed us that she had attended the emergency department with her child two days previously and had requested water. On this occasion they had waited 45 minutes and then, when the water had arrived, this had been warm.

In contrast, another relative informed us of repeated visits she had with her young child to the emergency department over previous weeks. This lady spoke highly of the support staff had given on each occasion to ensure her child was fed.

Other evidence
During our visit we did not identify any people within the emergency department who had specific medical dietary requirements. Staff confirmed to us that arrangements are in place to access food should this be required and appropriate. The food available meets cultural and special diet requirements.

The assessment form used by emergency department staff included a number of prompts to check the patient's hydration levels at various stages of their assessment and treatment.

The cold water dispenser was not working at the time of the visit, however, a jug of water and cups were available for people within the reception area. There was also a vending machine in the reception area, containing drinks and snacks.

Our judgement
Overall, we found that the trust was compliant with this outcome.

There are systems in place within the emergency department to assess and meet people's hydration and nutrition needs. There is easy access to drinks and snacks for people waiting to be seen.

Outcome 6:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

There are minor concerns with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
We spoke with a large number of people and their relatives during the visit.

On the day of the visit, the emergency department was not excessively busy and the majority of people or their relatives told us that they had experienced reasonable waiting times to receive treatment. However, some people had attended the emergency department in previous days and told us of long waiting times on these occasions. One person did inform of us of a long wait for discharge: this appeared to have been caused by a delay in receiving medication from the pharmacy.

Some people advised that they had first attended the Peterborough Walk In service, however, due to 2 hour plus waiting times, they had been referred on to the emergency department.

Two people advised that they had been directly referred to the emergency department by their GPs and, in both cases, that the GP had said they would ring ahead to announce their arrival. In both cases, the patients found that the emergency department had not been aware of any contact from the GPs.

Other evidence
Emergency department waiting times were discussed with the trust's management team, who confirmed that there had been some days during December 2010 where

waiting times in the emergency department had been unacceptable. The management team told us about a number of pressures that had created a backlog of people on some occasions. This had included bed blockages within the short stay area, which had been created by delayed discharges at the hospital. We were advised that this was in part related to the closure of beds within the City Care Centre, due to Norovirus. During our visit the trust received notice from the Primary Care Trust that a number of beds had become available allowing for move on.

Four ambulance staff advised that, since the emergency department had opened, there had been occasions where there had been long waits to hand people over to the hospital. One of the ambulance staff had experienced a delay of two hours and told us that on the particular day this had impacted on the ability of the ambulance service to attend other calls.

We were advised by the trust of ongoing discussions being held with the two main regional ambulance teams with which they work, in respect of emergency department waits. Some of the procedures in place include the possibility of diverting ambulances to other emergency departments.

At the time of our visit, the emergency department was not excessively busy and none of the patients we spoke with were found to have waited longer than the Department of Health four hour target that is currently in place.

Since our visit to the emergency department, there have been additional days where people have experienced significant waits for emergency treatment. There have also been occasions where ambulance staff have experienced delays in being able to handover people to emergency department staff. The trust has been served with performance warning notices by the primary care trust, which commissions the service, and are required to take immediate action to remedy this situation.

People had told us about a number of issues, which indicated that other local agencies are not fully aware of the emergency department's referral and treatment criteria. Staff also informed us of a large number of GP referrals of people who had flu like symptoms, saying that a number of these people had been inappropriately referred to the emergency department.

Our judgement
Overall, we found that improvements are needed for the trust to achieve compliance with this essential outcome.

We found a number of issues that indicate that the trust's partner agencies are not fully aware of the emergency department's referral and treatment criteria. These include: people that had been referred by their GPs where the emergency department had not been forewarned; people that had been re-referred on to the emergency department by the local walk-in service due to long waits within the initial service; and a number of inappropriate referrals to the emergency department.

Some people have been experiencing unacceptable waits for treatment in the emergency department since its relocation in early December 2010. Ambulance staff have also experienced delays in being able to handover people to emergency department staff. While the trust has adopted a range of measures to identify,

consider and resolve these issues, and there is no evidence that this situation has caused immediate risks to people, we were advised that this has caused inconvenience to people and resource issues for the ambulance services.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We spoke with a large number of people and their relatives during our visit.

A large number of people told us that they were impressed with the facilities at the emergency department and compared these very favourably to those of the former A&E department based at Peterborough District Hospital.

However, a large number of people informed us that signage both within and outside the emergency department was very poor. Examples were given by people regarding a lack of clarity regarding where to book in, the location of the toilets, and indications of where to park for accessing the emergency department.
A number of people and relatives also stated that car parking, particularly for dropping off people in emergency situations and for disabled people, are situated too far from the department's entrance.

A number of people said that, due to the large entrance doors, the waiting areas within the department are particularly cold.

Other evidence
We found that parking arrangements were confusing and there was no clear signage to indicate the location of the emergency department's front entrance. We also noted the absence of essential signage to indicate where to book in, triage arrangements and the location of toilets.

We noted during the visit that a number of ambulances had dropped off people at the department's front entrance, which is not the designated ambulance entrance. Security staff posted outside the hospital confirmed that they had directed ambulance staff to the front entrance, despite being aware of ambulance arrangements.

There were a number of equipment trolleys sited within public areas of the emergency department and a number contained devices that could cause a risk to people. Some doors in the assessment rooms were not closed and provided access to areas that should only be entered by appropriate staff through locked doors. Sharps bins for the disposal of needles were accessible within these rooms, which meant children and adults could be at risk if they put their hand in the bin.

Staff told us that the designated work areas and computer terminals sited within corridors in the emergency short stay ward were not adequate for their needs. They stated that the desks are very small and do not provide sufficient space for making paper notes. Staff also confirmed that it is difficult to maintain confidentiality in these circumstances.

Throughout the visit, we noted that the main entrance doors to the department were open for long periods of time and that the temperature of the foyer and waiting areas was very low.

There were problems with the doors leading from the emergency department in to the short stay area and some relatives were observed to be able to pull the doors open, overriding the locking mechanism. At other times it was noted that relatives were waiting a significant time for staff to open the doors for them.

Our judgement
Overall, we found that improvements are needed for the trust to achieve compliance with this essential outcome.

There is insufficient signage both within and outside the department to ensure people are clear regarding arrangements and facilities.

Car parking arrangements are unclear. This is particularly relevant to people with disabilities and to those dropping people off in an emergency.

We found examples of where security is inadequate and where the storage of equipment is unsafe.

Problems were found with doors, which meant a cold environment in some areas and difficulties in accessing the short stay area.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We did not directly involve people who use services in our assessment of the safety, availability and suitability of equipment.

Other evidence
We spoke with a number of staff during our visit and they told us that they were aware of how to access and order medical equipment and supplies.

Staff told us about the hospital's voice activated communication system, which is a device worn by all staff and is used to make immediate contact with colleagues and receive calls. Staff who can use the device told us that it is very useful and speeds communication with colleagues and other departments. However, we were informed that some staff were unable to immediately activate the system and this appeared to relate to the electronic recognition of certain regional accents. Staff also told us that there are poor reception zones within the hospital where the communication system does not function. However, staff did tell us that this system is used in addition to a tannoy and telephone communication systems.

Ambulance staff told us that where they had experienced delays in handing over people to hospital staff they had also found difficulty in accessing medical

equipment and gases.

Our judgement
Overall we found that the trust was meeting this essential outcome but, to maintain this, we have suggested that some improvements are made.

The trust uses a voice activated communication system in addition to other means of communication. While this is highly valued by staff, we were told that this does not always work adequately.

Ambulance staff told us that they had found some difficulty in accessing medical equipment and gases within the emergency department.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We did not directly involve people who use services in our assessment of the staffing.

Other evidence
In discussing waiting times with the trust's management team we were advised that there had been some days during December 2010 where waiting times in the emergency department had been unacceptable.

The trust told us that there have been high levels of staff sickness during recent weeks. During these periods this has led to a heavy reliance on agency staff and staff from other departments. Staffing attendance records and planned rotas for the period 12 to 25 December 2010 showed that cover had been used to ensure that staffing was in line with regular numbers.

The emergency department now incorporates a number of functions of the previous district hospital. These include the former accident and emergency, the acute assessment unit and direct GP referrals. These services had combined and a single team now works across all of the functions. Staff had received development training prior to the move of hospitals and arrangements are in place to ensure co working of experienced A&E nurses with less experienced colleagues. We were provided with details of individual staff's training and experience, which was analysed against the

rotas. We found that there were acceptable levels of staff with A&E experience available at all times.

At the time we visited the department, there was no registered children's nurse on duty. We discussed this with the management team, who told us that while the majority of emergency department staff are general nurses they also receive specialist training in a range of children's needs. The department is also situated adjacent to the children's inpatient services and emergency department staff told us that they receive support and advice from this service as required.

Our judgement
Overall we found that the trust was compliant with this outcome.

The trust had systems in place to assess and monitor emergency department staffing levels and had increased staff in line with their findings.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are moderate concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not directly involve people who use the services in the assessment of compliance with keeping essential records.

Other evidence
At the beginning of our visit we found that the assessment documents of people had been stored close to a glass partition within the reception area. The personal details of people were visible to us and it would have been possible to remove these records from the public side of the partition. This matter was immediately raised with staff, who removed the records; however, later in the visit we noted that further records had been placed in the same position.

The reception staff told us that the records had been placed in this position because there is a lack of storage space within the reception area.

An audit of attendance at the emergency department occurring in the previous week was provided, which indicated that staff were not always recording start and end times for attendances. It was noted that a person's assessment record did not include full details of start and end times. We also observed an occasion where a person's notes could not immediately be located, causing a delay in treatment.

Our judgement
Overall, we found that improvements are needed for the trust to achieve compliance with this essential outcome.

We found that individual records were not being stored securely. This does not meet the requirements of the Data Protection Act 1998 or guidance from the Department of Health regarding records management.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the 1983 Act Surgical procedures Diagnostic and screening procedures	16	11
	Why we have concerns: Overall we found that the trust was meeting this essential outcome but, to maintain this, we have suggested that some improvements are made. The trust uses a voice activated communication system in addition to other means of communication. While this is highly valued by staff we were told that this does not always work adequately. Ambulance staff told us that they had found some difficulty in accessing medical equipment and gases within the emergency department.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the 1983 Act Surgical procedures Diagnostic and screening procedures	17	1
	How the regulation is not being met: Overall we found that improvements are needed for the trust to meet compliance with this essential outcome. We found confusion regarding booking in and triage arrangements and that people did not feel the process was effective or allows sufficient privacy. We found that there is insufficient information available for people regarding the service, types of injuries or waiting times. This is particularly relevant to people whose first language is not English.	
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the 1983 Act Surgical procedures Diagnostic and screening procedures	9	4
	How the regulation is not being met: Overall we found that improvements are needed for the trust to meet compliance with this essential outcome. Some people have been experiencing unacceptable waits for treatment in the emergency department since its relocation in early December 2010. The trust has adopted a range of measures to identify, consider and resolve these issues. Initiatives have included working with partner agencies to resolve discharge problems and capacity risks, a range of internal processes to review bed capacity and resolve discharge problems on a frequent basis, and the redeployment of additional staff across the emergency department and within other key services. While there is no evidence that this situation has caused immediate risks to patients we were told that this has caused inconvenience in some circumstances.	
Treatment of disease,	24	6

disorder or injury Assessment or medical treatment for persons detained under the 1983 Act Surgical procedures Diagnostic and screening procedures	**How the regulation is not being met:** Overall we found that improvements are needed for the trust to meet compliance with this essential outcome. We found a number of issues that indicate that the trust's partner agencies are not fully aware of the emergency department's referral and treatment criteria. These include: people that they had been referred by their GPs where the emergency department had not been forewarned; people that had been re-referred on to the emergency department by the local walk in service due to long waits within the initial service; and a number of inappropriate referrals to the emergency department. Some people have been experiencing unacceptable waits for treatment in the emergency department since its relocation in early December 2010. Ambulance staff have also experienced delays in being able to handover people to emergency department staff. While the trust has adopted a range of measures to identify, consider and resolve these issues, and there is no evidence that this situation has caused immediate risks to people, we were advised that this has caused inconvenience to people and resource issues for the ambulance services**.**	
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the 1983 Act Surgical procedures Diagnostic and screening procedures	15	10
	How the regulation is not being met: Overall we found that improvements are needed for the trust to meet compliance with this essential outcome. There is insufficient signage both within and outside the department to ensure people are clear regarding arrangements and facilities. Car parking arrangements are unclear. This is particularly relevant to people with disabilities and to those dropping people off in an emergency. We found examples of where security is inadequate and where the storage of equipment is unsafe. Problems were found with doors which meant a cold environment in some areas and difficulties in accessing the short stay area.	
Treatment of disease,	20	21

disorder or injury Assessment or medical treatment for persons detained under the 1983 Act Surgical procedures Diagnostic and screening procedures	**How the regulation is not being met:** Overall we found that improvements are needed for the trust to meet compliance with this essential outcome. We found that individual records were not being stored securely. This does not meet the requirements of the Data Protection Act 1998 or guidance from the Department of Health regarding records management.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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