**Mid Staffordshire NHS Foundation Trust**  
**Stafford Hospital**

<table>
<thead>
<tr>
<th>Region:</th>
<th>West Midlands</th>
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<tbody>
<tr>
<td>Location address:</td>
<td>Weston Road</td>
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<td>Stafford</td>
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<td>Staffordshire</td>
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<td>ST16 3SA</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<tr>
<td>Date of Publication:</td>
<td>November 2011</td>
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<td>Overview of the service:</td>
<td>Mid Staffordshire NHS Foundation Trust is the main provider of acute emergency &amp; planned general hospital services, community midwifery and paediatric services in and around South Staffordshire. The trust operates from two main hospital sites. Stafford Hospital has 360 inpatient beds and the main accident and emergency department for the area. Cannock Chase Hospital has 98 inpatient beds</td>
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and a minor injuries unit which is open from 8am to 12 midnight.
Our current overall judgement

**Stafford Hospital was not meeting one or more essential standards. Improvements are needed.**

The summary below describes why we carried out this 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:

**Outcome 13 - Staffing**

**How we carried out this review**

We reviewed all the information we hold about this provider, carried out a visit on 15 September 2011, talked to staff, reviewed information from stakeholders and talked to people who use services.

**What people told us**

Some patients told us that they had been waiting for up to three hours and that no-one had communicated with them as to how long they would have to wait. One patient's relative told us they were informed about the treatment plan but they had been in the department a long time and felt that staff were very busy.

Other patients told us that they would not re-visit the hospital again by choice because of the long wait and lack of communication.

**What we found about the standards we reviewed and how well Stafford Hospital was meeting them**

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

The system for covering emergency staff absences is not always effective on occasions causing a deficit in staff numbers. Patient care is compromised by a lack of experienced, qualified staff.

**Actions we have asked the service to take**

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take
enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

In a previous review, we found that improvements were needed for the following essential standards:

- **Outcome 09:** People should be given the medicines they need when they need them, and in a safe way

- **Outcome 14:** Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Please see previous reports for more information about previous reviews.
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 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
There are major concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We were told by patients in the Accident and Emergency department (A & E) that they felt safe and that their health needs were being met by the staff, although staff told us that sufficient numbers of appropriately trained staff were not always on duty.

One person in the observation unit told us "The staff are marvellous, so kind and helpful. I don't want to stay in overnight but the staff have made me feel very comfortable and I am reassured about the situation. From the moment I came into the department the staff have been attentive and told me what the plan was."

We saw that some people were being kept in over night and were asleep in various areas of the department. The privacy and dignity of one person was compromised when they were trying to sleep without the curtain being pulled around the bed for privacy.

Other evidence
We spoke to a number of the staff on duty, during two night visits. The staff we spoke to were of various grades and positions. Staff told us that at certain times in the A & E Department there were not sufficient staff with the right skills, qualifications and/or experience to meet the needs of the people who use the service.

Due to the layout of the department it is difficult for the staff on duty to be able to observe all of the patients, when the department is busy and people cannot be accommodated in the resuscitation or observation bay areas and their care is managed...
in the corridors.

We looked at the rotas for the A & E department which show which staff are on duty and when. These demonstrated that there were not were not sufficient numbers of staff on duty at all times.

We were told by staff that the staffing provision in A & E did not always allow for the small number of newly qualified/inexperienced staff to be appropriately supervised and supported by senior staff and this was due to the recent unmanaged staff shortages due to high sickness levels.

We were told that the bank staff did not always have the necessary skills to work in A & E. We were also told that the system for covering emergency leave was not effective; regularly leaving a deficit in numbers. It was reported that this was a fairly recent deterioration and that since the summer the trust were unable to respond to unexpected changing circumstances in the service. Staff said that the inability to book agency staff had exacerbated the problem.

Staff informed us they were appropriately managed, however they said that they felt that the pressure of targets and data were more important than patient care and their professional, nursing opinion. Staff who were on duty told us that they felt that the staff shortages caused unnecessary pressure on the senior staff as there were not enough skilled staff on duty, in sufficient numbers.

Staff told us that they felt that the management were not listening to their concerns and that their problems had not been sorted out.

Staffing levels were already a concern to the CQC and we had previously issued a compliance action, which required the trust to ensure that they had sufficient numbers of suitably qualified and experienced staff. Our inspection identified that the trust is still not compliant with the regulation that relates to staffing and therefore as a result of this inspection we have issued a warning notice with a short timescale. We will be revisiting the trust to ensure that they have taken the appropriate steps required to ensure compliance.

In view of the major concerns identified in this outcome area the Care Quality Commission served a warning notice on the Registered Provider on 23 September 2011.

**Our judgement**
The system for covering emergency staff absences is not always effective on occasions causing a deficit in staff numbers. Patient care is compromised by a lack of experienced, qualified staff.
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 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

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<tr>
<th><strong>Document purpose</strong></th>
<th>Review of compliance report</th>
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<tr>
<td><strong>Author</strong></td>
<td>Care Quality Commission</td>
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