The Pennine Acute Hospitals NHS Trust

North Manchester General Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

North Manchester General Hospital is one of the main locations providing inpatient care as part of The Pennine Acute Hospitals NHS Trust. It provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

The Pennine Acute Hospitals NHS Trust provides services for around 820,000 people in and around the north east of Greater Manchester in Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham, Rochdale and parts of East Lancashire. There are approximately 1191 inpatient beds across the Trust with the North Manchester General Hospital having 481 inpatient beds.

We carried out an announced inspection of North Manchester General Hospital between the 23 to 3 March 2016 as part of our comprehensive inspection of The Pennine Acute Hospitals NHS Trust.

Overall, we rated North Manchester General Hospital as Inadequate. Improvements were needed to ensure that all services were safe, effective, well led and responsive to people's needs.

However, we found that the majority of services apart from Children and Young people services were provided by dedicated, caring staff, and patients were treated with dignity and respect

Our key findings were as follows:

Incident Reporting

- There was not a strong culture of reporting and learning from incidents in the hospital. This was evidenced by practice we saw in the;
- Urgent and emergency, medicine, maternity and gynaecology and children and young people departments.
- There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm.
- Some staff said that they did not always report incidents because they felt that little was done when they reported them. When staff did report incidents they told us that they did not always receive feedback.
- There were occasions when we had to prompt members of staff to report incidents for things such as equipment that was overdue a service, inappropriately stored drugs and out of date disposable equipment. Staff did not demonstrate awareness that these needed to be reported and required several prompts throughout the inspection to report incidents.
- Incidents were not always investigated in a timely way and staff did not always receive feedback from incidents.
- Risks were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate risks in the longer term.
- Learning was not shared through established systems and channels with a lack of openness about outcomes.
- There was a lack of learning from complaints and a lack of learning and sharing of knowledge from discussions about mortality and morbidity.

Summary of findings

- However within the surgical, critical care, end of life and outpatient and diagnostic departments we saw evidence of a safer culture where systems were in place to ensure incidents were reported, investigated and lessons learnt.

Cleanliness and infection control

- There were a number of departments in the hospital where there were concerns regarding cleanliness and infection control. These included medicine, surgery, maternity and gynaecology and Children's and young people's services
- The environment posed an issue on a number of the medical wards we visited. Wards shared facilities or patients were co-located on medical wards meaning staff had to walk through different wards and departments to access the dirty utility or care for patients.
- There was no risk assessment completed to address this issue or minimise any potential risks.
- There were also no plans in place to manage the issues on the medical wards if there was an outbreak of norovirus, MRSA, C-difficile or carbapenemase producing enterobacteriaceae (CPE).
- There were no hand washing facilities when walking between some wards. There were no toilet facilities on some patient bays. This meant that patients shared toilet and washing facilities with patients from different bays. There were no plans in place to manage this if there was an outbreak of infection.
- There were few side rooms available on medical wards which meant that it was not always possible to isolate patients as required.
- A number of wards were 'Nightingale' style wards which limited the ability to isolate or cohort groups of patients with infections to prevent the spread of infection
- Within maternity and gynaecology there were incidences of puerperal sepsis at a higher rate than would be expected for a service of this size.
- On the labour ward there was no infection control information displayed such as results of hand hygiene audits or infection rates. This should be displayed as part of the safety thermometer data
- Within the children's and young people's service hospital audits for MRSA and C.Diff were reactive. From June 2015 to October 2015 the children's wards, Koala unit and the neonatal unit were not audited for C.diff or MRSA.
- The paediatric wards at NMGH were audited in August 2015. They were found to be 67% compliant with hand hygiene. We saw no evidence there was a re-audit in the information we were provided and saw no action plan to address this.

However

- The hospital had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- In the Emergency and urgent care department all areas were visibly clean, with no reported occurrences of methicillin-resistant staphylococcus aureus (MRSA) or colostrum difficile (CDIFF).

Medicines management

- Overall we found the medicines were well managed across departments with some issues in the End of life department
  - Medicines including controlled drugs were stored securely in line with legislation.
  - Staff carried out checks on controlled drugs to ensure compliance with their medicines policy and records indicated that checks were completed correctly on the majority of occasions.
  - We saw that medication was in date and stored appropriately.

Summary of findings

- Medicines requiring cool storage at temperatures between two and eight degrees centigrade were appropriately stored in fridges. However, records indicated that daily checks had been missed on a number of occasions.
- We checked a sample of patient medication charts which had been correctly documented and signed for.
- Pharmacy staff were responsible for maintaining stock levels across the hospital.
- There was a trust wide antibiotic policy for adults in place. The most recent audit in July 2015 showed that 98.6% of antibiotics prescribed at NMGH were compliant with this policy. Staff told us the policy was clear and easy to follow.
- We observed a nurse giving a patient medication that was due to be transferred to another hospital. The medication was given so that it was not delayed by their discharge. The medication was given and documented on the electronic prescribing system so that the medication could not be given again at the new hospital.
- In the surgical department staff told us that they tried to pre-empt patients for discharge at weekends and where necessary they could dispense patient's medication to take home from the ward.
- Children were weighed and this was documented within their medical records.

However

- In the End of life department we reviewed prescription charts for seven EOL patients spread across different wards. Three patients had not been prescribed all of the recommended anticipatory medication. We returned and reviewed one of these charts 24 hours later, but the anticipatory medicine prescriptions were still not in place.

Nursing staffing

- There were a number of departments in the hospital where there were concerns regarding nurse staffing. This was particularly significant within the medicine, maternity and gynaecology and children's and young people's services (CYP)
  - Consideration of the safer staffing guidelines produced by the National Institute for Health and Care Excellence (NICE) had been taken when determining the nursing staffing required in most departments apart from CYP.
  - The use of bank and agency staff was high and they were used on most days to fill vacancies and cover sickness. This had recently been stopped for one agency in the CYP due to the agency not complying with the national agency cap. However the use of agency staff from that agency had been reintroduced since our inspection.
  - We found that the average sickness rate and staff turnover rate in a number of departments was above the trust target of 5%
  - On some medical wards the acuity and dependency of patients on this ward was high. Staff told us that staff shortages meant that essential nursing tasks could not be undertaken in a timely way. For example, intravenous (IV) medications or fluids were given late, dressings were not completed and that there had been an increase in the number of hospital acquired pressure ulcers due to late or incomplete pressure area care.
  - The critical care unit did not meet the standard for supernumerary cover. The nurse in charge of the each unit was working clinically to care for patients. This issue was well known to the trust and was highlighted as a concern in the May 2015 review by the GMCCN.
  - Within CYP department we found that 19 out of 20 shifts (95%) were not staffed in accordance with RCN guidance in terms of the recommended staff: patient ratio. On average each shift was understaffed by two registered nurses.
  - We reviewed the planned vs actual staffing figures on the CYP ward. In 32 out of 92 shifts (34.78%) nurse staffing was at least one registered nurse short.

Summary of findings

- Royal College of Nursing (RCN) standards (August 2013) recommends that a nursing staff member has advanced life Support (APLS) training at all time throughout the 24 hr period. The trust did not have any APLS trained nursing staff members in paediatrics. They informed us that 13/46 (28.3%) nurses had current paediatric life support (PILS) certification on paediatrics.
- Nursing staff told us that regularly they did not take all their breaks.
- High dependency patients are nursed on the paediatric ward where staff had not received additional training for this this dependency of patient. This is against Paediatric Intensive Care Standards.

However

- On CCU, the average fill rate was lower for RNs during the day at 90% however; this remained above the trust target and national benchmark of 80%.
- A paediatric advanced nurse practitioner and paediatric nurses were employed by the urgent and emergency care department.
- The department always had at least one paediatric nurse on duty at all times which met the royal college of nursing (RCN) guidelines.
- A letter dated 17 February 2016 was seen addressed to the staff from the chief nurse in response to their recent concerns about staffing shortfalls within the surgical department. The outcome was to arrange a staff meeting with the chief nurse. Staff said they felt assured by the chief nurse's involvement and the staffing proposals to recruit two healthcare support workers in the future.

Midwifery staffing

- The numbers of midwives to birth ratio was worse than the England average.
- Information provided by the trust showed one to one care in established labour did not meet the 100% of births target between April and October 2015. The lowest was 96.5%.
- All the midwives and managers we spoke with stated staffing issues were their major concern for the maternity services. This had been recognised by the trust and the "failure to achieve safe staffing levels" was on the risk register.
- Managers on the wards were unsure how their staffing establishment had been calculated and why there were variations.
- Measures to improve midwifery staffing such as recruitment had been less successful than expected.
- On the rota for 7 March to 3 April 2016 there were 204 vacant shifts in the labour ward
- Midwife numbers were significantly below those planned on the labour ward. For week commencing 22 February 2016 nine shifts were not staffed to the planned level of eight midwives with weekends having six per shift. One day there had been four midwives instead of eight. This had been escalated and the managers worked in a clinical capacity.
- We saw staff who had worked since 7.30am and had no break at 3.45pm.
- Between 1 December 2014 and 30 November 2014 there were 46 incidents of shortage of staff reported.
- There was a high level of sickness among the midwives.
- Information provided by the trust showed the turnover rate was 13.4% between 1 February and 31 January 2016.

Medical staffing

Summary of findings

- There were a number of departments in the hospital where there were concerns regarding medical staffing. This was particularly significant within the Urgent and Emergency Care, medicine, maternity and gynaecology and children's and young people's services (CYP)
  - Within the Urgent and Emergency (U&E) care department an establishment of nine consultants had been commissioned. Only one of these was employed substantively at the time of the inspection. However, consultants from other areas of the trust worked in the department on a rotational basis to provide support.
  - The paediatric consultant did not currently work in the department due to being seconded into another role within the trust, support was provided by a paediatric advance nurse PR actioner.
  - The U&E department were established for seven middle grade positions and 13 junior doctor positions. However, only three middle grade doctors and five junior doctors were employed substantively at the time of the inspection. As a result, the department relied heavily on locum doctors of all grades
  - The U&E department had received funding for additional doctors due to winter pressures. However, we found that these had been filled on only a minority of occasions during the same period.
  - There was limited assurance that the performance of locum doctors with U&E was being reviewed on a regular basis. This was important as locum doctors formed a large percentage of the medical workforce within the department.
  - Medical handovers within the U&E department were not always facilitated on a daily basis. On one occasion that the senior doctor in the department had to request information from the nursing staff to find out about patients who were currently in the department.
  - There were high levels of locum use on Medical Emergency Unit (MEU) in particular for junior, middle grade and consultant cover. 70 percent of medical shifts had been filled by a locum doctor between October 2014 and March 2015. Locum usage for general medicine was 51% and care of the elderly was 39%.
  - One junior doctor told us that shifts and staffing on MEU did not always meet the needs of patients. For example, there were always more admissions to be clerked during the afternoon but these admissions were often left waiting for the night team to clerk them. This meant that patients could wait for long periods to be seen by a medical doctor.
  - On the maternity unit doctors of various grades told us some consultants who were on call from home over the weekend were reluctant to attend if called for support. An example was given of when support was requested with the delivery of a baby; however the consultant did not attend. This concern was raised with the trust and assurance given that all consultants worked within the guidance.
  - Consultant presence was not in place on the paediatric wards during peak times as per the facing the future standards. The trust advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.
  - Facing the Future Standards also recommend that every child who presents with an acute medical problem is seen by a consultant, or equivalent, within 24 hours. In one paediatric serious incident investigation we reviewed this had not occurred and was deemed a causal factor in the delay of diagnosis. The trust did not monitor this standard at the time of our inspection.

However

- The surgical service had similar levels of junior grade doctors and higher levels of consultants compared to the England average.

Summary of findings

- The surgical wards and theatres we inspected had a sufficient number of medical staff with appropriate skill's to ensure that patients received safe care.
- The SPC team was clinically led by a full time consultant in palliative medicine.
- Within the OPD department consultants reported no gaps at consultant level and clinics were consultant led.
- Consultant radiology cover was provided on site Monday to Friday 9am to 5pm. Radiology on call services were provided weekday evenings 5pm to 9pm on a trust wide rota supported by the trust consultants and between 9pm to 9am general on call services were provided by an on call contractor.

Access and Flow

- There were a number of departments in the hospital where there were concerns regarding access and flow. These included Urgent and Emergency care medicine, critical care, maternity and gynaecology and Children's and young people services
  - The Urgent and Emergency department had continuously failed to meet national targets to see, treat, discharge or admit patients within 4 hours. Records showed that between July and November 2015, performance had continually deteriorated.
  - The department also failed to meet the department of health 1 hour target which measured the time of arrival to the time of definitive treatment within the same period.
  - Records indicated that there had been a high number of patients waiting for over 12 hours in the department. As a result of the trust's decision to admit policy these were not always recorded appropriately potentially providing and inaccurate picture of performance and limiting the ability to improve the service.
  - Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers).
  - There were total 1,002 patients moved overnight between November 2014 and October 2015. The majority (871) of these moves were from MEU. Trust policy was that patients should not be moved between 8pm and 8am. Large numbers of patients experience multiple ward moves during the night
  - Some wards had very high bed occupancy rates, for example in October and November J3 had a bed occupancy rate of 98.3% It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
  - Patients waited on MEU for longer than necessary due to bed shortages. One patient had been waiting for a medical speciality bed for seven days.
  - Staff on Coronary Care Unit (CCU) told us that there was often a wait to step patients down from this unit to beds on other medical wards. On the day we visited this unit, two out of six patients no longer required the level of care provided on CCU and were awaiting medical beds. This meant that patients needing admitting to CCU may not be able to access the care they need although bed occupancy rates were lower on CCU, at an average of 86.6% between October and December 2015.
  - Beds on the Infectious Diseases (ID) ward were often filled with outlying medical patients. This meant that patients requiring bronchoscopies for suspected tuberculosis (TB) waited for up to 12 weeks for this investigation. Specialist negative pressure rooms could not be used for their intended purpose. There had previously been a trolley area that was used to provide specific specialist treatment to patients with HIV but this was now in use as a medical bed.

Summary of findings

- Discharge plans were discussed during nursing handovers. There was a patient flow team available Monday to Friday who supported staff with issues regarding access and flow. Staff told us there were often long delays for packages of care to be arranged. Divisional leads told us that approximately 20% of medical beds across the trust were filled with delayed discharges.
- On the day of our visit to the treatment centre, there were two male patients who had undergone lung biopsies on the unit. Staff told us that usually these patients were admitted to ward C3 following the procedure for monitoring, but on this day there were no available beds. The centre was therefore being used inappropriately due to a lack of surgical beds.
- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from critical care there was often a delay in discharge.
- There was a problem with delayed and out of hours discharges. Access and flow performance was tabled at the monthly critical care directorate meetings; though it is not clear from the minutes what actions, if any, the unit are taking to try improve the position for patients.
- During the 12 months from December 2014 to December 2015, 6 patients had been ventilated outside the critical care unit.
- Both the outpatient department (OPD) and the radiology department had high levels of patients who did not attend and there were no plans in place to address this.
- Due to capacity and staff shortages on the labour ward we saw delays in transfers from the antenatal ward or maternity assessment unit did occur. Between January and November 2015 there had been 10 births in areas of the maternity unit other than the labour ward. There was no record of emergencies transfers following delay.
- We saw nine patients waiting for their inductions to be progressed and were told at least three had waited beyond two hours which had been raised as a staffing red flag incident due to lack of midwives.
- On the paediatric unit beds were not permitted to be closed to GP admissions. This meant that even when the escalation policy had been followed and risks agreed, the ward would not be fully closed.

However

- Between November 2014 and October 2015 referral to treatment times (RTT) for all medical specialities including cardiology and gastroenterology were above the England average and the trust target of above 92%. General medicine and geriatric medicine were 100% compliant with the 18 week RRT.
- The average length of stay at NMGH for the top surgical three specialities identified by HES data (July 2014 – June 2015) confirmed that the average length of stay for elective urology and trauma and orthopaedics was lower than the England average.
- The referral to treatment times (RTT) and the cancer waiting times were better than the England average
- There was no reporting backlog for any of the modalities for radiology. The patient tracking list group was chaired by a clinician and addressed individual patient issues along the cancer pathways.
- The maternity assessment unit provided open access for patients who were 16 weeks pregnant and above. Patients could self -refer if they had concerns, or be referred by their GP or the emergency department.
- Midwives could discharge patients from the maternity assessment unit without medical review. This meant there were no delays in discharge from this area.

Summary of findings

- Within the end of life service there were two rapid discharge initiatives in place. One was the rapid transfer pathway, which referred to EOL patients under the care of the SPC team who wished to leave hospital to their preferred place of care.
- Staff told us pharmacy prioritised anticipatory medication when identified it was needed for rapid discharge, and that an agreement was in place with North West Ambulance Service (NWAS) for them to attend within two hours.

Leadership and Management

- There were a number of departments in the hospital where there were concerns regarding leadership and management. These included U&E medicine, surgery, maternity and gynaecology and Children's and young people's services.
- The leadership for the departments had a clear structure. However, the majority had only been implemented three months before the inspection and some senior members of the teams had only been in post a few weeks.
- We saw that leaders were visible within the majority of departments and that they interacted well with staff. However midwives told us they saw the midwifery lead "never", "rarely" and "occasionally" on the wards and departments. Although they reported having seen other leaders in the service more frequently.
- Some band seven and six nurses felt that the leadership was blame focussed and not supportive and that that they felt they could not be honest during the inspection team staff focus group.
- Senior nurses told us that they rarely received positive feedback.
- Staff identified some concerns about the lack of senior support for the dietetic service as the previous manager left in January 2016
- Human resources issues were not managed in a timely way to ensure the right people were in the right job. Senior medical staff discussed some concerns regarding the employment of seven locum consultants where integration into the substantive team, or their replacement with permanent staff had not progressed for four years.

However

- Staff told us that there had been a positive change in the overall leadership of the trust in the past 18 months. The chief nurse regularly visited wards and departments
- A new 'Transforming Leaders' course was open to all senior managers and clinical directors

We saw several areas of outstanding practice including:

- The introduction of PCR testing for clostridium-difficile ensured rapid results were available to medical teams to reduce the potential spread of infection within inpatient areas.
- The paediatric unit had created specific packs to support parents whose children were having specific procedures for example a DVD and self-help pack had been created for children having spiker surgery. This included contact details for parents who had had a similar experience.
- The neonatal unit had a range of leaflets that complemented their 'baby passport'. The leaflets were staged depending on the baby's development. Parents were prompted via the 'baby passport' and nursing staff to know which information leaflets were relevant to them at a particular point in time.

Importantly, the hospital must:

Urgent and Emergency Care

- Ensure that the staffing recommendations made by the peer review are considered and that the staffing establishment is correct for the department.
- Ensure that there are sufficient numbers of trained staff within the department who can resuscitate adults and children when necessary.

Summary of findings

- Ensure that staff has access to and receive a yearly appraisal in a timely manner so that their training needs can be identified and so that their skills and knowledge can be developed.
- Ensure that a site induction and a sufficient level of clinical supervision are provided to locum staff who work in the department.
- Ensure that newly qualified nursing staff receive the appropriate supernumerary period in line with trust policy in order to ensure patient safety.
- Ensure that is made clear how the minor injuries area is used and make sure that if high acuity patients are managed in this area it is done by the correct level and numbers of staff.
- Ensure that daily checks and relevant documentation of controlled drugs are completed correctly and accurately in line with legislation and trust policy on every occasion.
- Ensure that staff check resuscitation equipment on a regular basis so that out of date equipment is identified in a timely manner.
- Ensure that patients receive a full assessment and appropriate treatment in a more timely manner so that patient risk is better managed.
- Ensure that staff are always escalating patients who trigger the sepsis pathway for immediate medical review.
- Ensure that call bells are available in all cubicles and that patients are given call bells to alert staff if they require assistance when needed.
- Ensure that an up to date escalation plan is used in managing the department. This must identify all of the risks that the department faces and support staff in managing those risks.
- Ensure that all incidents of patients waiting for more than 12 hours are reported as serious incidents and are investigated using the appropriate serious incident framework.

Medical Services

- Ensure that patients staying overnight at the Manchester treatment centre have facilities to wash and store personal belongings.
- Ensure that records are completed in line with best practice guidance and are maintained and stored securely.
- Ensure that incidents are investigated promptly and learning is shared through formal, established channels. Mortality and morbidity must be discussed and learning shared.
- Ensure that plans are in place for wards sharing facilities and staff in the case of an outbreak of infection.
- Ensure that staff receive training on and understand how to apply the Mental Capacity Act and deprivation of liberty safeguards.
- Ensure that staff follow the hospital standard for adult patient observation practice
- Ensure that intentional rounding is completed in a timely and effective way.
- Ensure that assessments of nutrition and hydration are completed for all admitted patients.
- Ensure that mental capacity and deprivation of liberty is considered and documented on the bed rail assessment document.
- Ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.

Summary of findings

- Ensure that processes are in place to share and respond to patient safety alerts.

Surgical Services

- Ensure that staff understand and act in line with the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.We spoke with five staff. Two staff had no knowledge and two staff were waiting to receive training.
- Ensure that patients do not attempt resuscitation documents and supporting documentation is fully completed and review dates identified.
- Ensure all nursing and medical staff have annual appraisals completed.
- Ensure that staff complete training in 'Sepsis six' so staff are aware of the process to follow when a patient is put on a 'Sepsis six' treatment pathway.
- Ensure that critical care beds are available for surgical patients who require their initial post-operative care to take place in a designated critical care unit so that they receive treatment and care from staff who have the skills and training in this area.
- Ensure that patients who are outliers on wards have the appropriate care, review and support to ensure a positive outcome results from their treatment.
- Ensure that all yellow clinical waste bins when in use are locked.
- Ensure formalised surgical service strategies are put in place.
- Ensure incidents are reported in accordance to trust policy
- Ensure that monitoring of drugs fridges take place as per hospital policy.

Critical care

- Ensure action is taken to reduce the numbers of delayed and out of hours discharges from critical care.
- Ensure that the management of sharps complies with infection control and health and safety guidance.

Maternity and Gynaecology

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the maternity services.
- This includes sufficient consultant resident cover in the labour ward.
- Assess the risks to the health and safety of patients of receiving the care or treatment.
- (To complete EWS / neonatal EWS / ante-natal risk assessments)
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
- (Investigate incidents within agree timescales and take action to prevent recurrence)

Children and young People

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the paediatric and neonatal services.
- This includes sufficient medical cover.

Summary of findings

- Ensure risks are assessed with regard to the health and safety of patients of receiving care or treatment.
- Ensure they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
- Ensure that electrical equipment is appropriately maintained and fit for purpose.

End of Life Care

- Ensure patients are prescribed all of the recommended anticipatory end of life medications.

In addition the hospital should:

Urgent and Emergency care

- Encourage staff to report all incidents in line with the trust policy.
- find ways in which incidents and complaints are disseminated back to all staff so that learning and service improvement is facilitated.
- check that unused equipment is stored in clean areas and that used equipment and waste is kept in appropriate areas.
- consider keeping the doors to the children's area locked at all times so that unauthorised people do not enter.
- consider the safe storage and accessibility of resuscitation equipment, particularly in the children's department.
- Keep records for safeguarding peer reviews in a way that can be measured and used to inform service improvement.
- Use all appropriate resources in supporting patients living with dementia in line with the trust policy.

Medical Services

- Consider implementing an action plan into improve performance on the national heart failure audit.
- Consider that patients are discharged from hospital as soon as they are medically fit.
- Consider that the use of escalation beds and additional bed capacity is monitored and reviewed.
- Consider that complaints are managed in a timely way.
- Consider how to make changes to the layout and design of wards and departments to reduce the risk of spread of infection, including the abolishment of Nightingale style wards and the provision of additional side room capacity.
- Consider how nursing skill mix is determined on wards where bank or agency staff are regularly being used.
- Consider how to ensure specialist beds on the infectious diseases ward can be used for their intended purpose.
- Consider how to reduce the risk of mixed sex breaches in the Manchester treatment centre.
- Consider how to ensure that there is an open, honest and supportive culture within medical services.

Surgical Services

- Consider improving staff understanding of the trust core values and what they involve.
- Consider a better staff knowledge of the 'Duty of Candour' is developed.
- Consider ways to ensure that patient's meal times remain protected.
- Consider that medical staff receive sufficient supervision and that work-based assessments are completed.

Summary of findings

- Consider ways to improve staff attendance at infection control (patient handling) training
- Consider introducing a mandatory training summary for the surgical service that is available which identifies compliance levels for mandatory training sessions for all staff groups. Where there are, shortfalls in mandatory training noted then actions should be taken to identify how to improve compliance.
- Consider introducing a system where all resuscitation equipment has expiry dates identified and that this information is noted on the resuscitation equipment checklist.
- Consider introducing a formalised and documented induction checklist which are in place for bank or agency staff who are working on the clinical area for the first time

Critical care

- Consider that there is a supernumerary band 6/7 shift co-ordinator on duty 24/7.
- Consider updating and reviewing the critical care risk register on a regular basis ensuring all risks with actions are included.
- Consider how it can embed training on Duty of Candour to all staff.
- Consider how it is going to embed the delirium strategy into the day to day care of patients receiving critical care.
- Consider how it is going to meet the intensive care society standards for the provision of pharmacy and allied health professional support to the critical care service.

Maternity and Gynaecology

- Consider including actions and sharing lessons learned following the mortality or morbidity meetings to use them to improve practice.
- Consider having a system to provide feedback, develop actions and share learnings from complaints.
- Consider introducing a system to check the completion of fluid intake and output charts.
- Consider introducing a system to protect community midwives when they are lone working.
- Consider keeping staff mandatory training and that specific to the role they completed up to date at all times.
- Consider a safety message being delivered at handover
- Consider multidisciplinary handovers on the labour ward
- Consider how consultants on call from home respond to requests to attend the labour ward in order to meet the RCOG recommendations.
- Consider introducing mechanisms to reduce the delays in induction of labour.
- Consider implementing actions from audits.
- Consider how the information on the maternity dashboard can be used to inform and improve practice.
- Consider making sure all staff appraisals are up to date.
- Consider training all staff in the application of the principles of the Mental Capacity Act.
- Consider whether the location of the maternity assessment unit is suitable to meet its purpose.
- Consider how risks are managed.
- Consider improving the engagement with staff and the public.

Summary of findings

Children and young People

- Consider including actions and sharing lessons learned following the mortality or morbidity meetings to use them to improve practice.
- Consider having a system to provide feedback, develop actions and share learnings from complaints.
- Consider keeping staff mandatory training and that specific to the role they completed up to date at all times.
- Consider nursing staff presence at morbidity and mortality meetings.
- Consider how it is going to meet the facing the future standards
- Consider implementing actions from audits
- Consider how the information on the paediatric and neonatal dashboards can be used to inform and improve practice.
- Consider making sure all staff appraisals are up to date.
- Consider how risks are managed.
- Consider improving the engagement with staff and the public.

End of life Care

- Consider developing a clear policy that defines the different rapid discharge processes with targets for the time taken.
- Consider implementing a seven day service is in place and the risk to patients is mitigated
- Consider implementing the IPOC and it is disseminated to the wards and fully embedded.
- Consider the completing uDNACPR documentation so it meets the required standards.

Outpatients and Diagnostics

- Continue to reduce the waiting times for the diagnostic procedures of colonoscopy, gastroscopy and sigmoidoscopy.
- Consider the replacement of the allied health professional senior manager for the trust.
- Reduce their did not attend rates in the OPD and in radiology.
- Ensure that in paediatric outpatients staff are up to date with their appraisals.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate	We judged emergency and urgent care services to be 'inadequate' because; The department had continuously failed to meet the department of health target to see, treat, discharge or admit 95% of patients within 4 hours. Records indicated that there had been a high number of patients waiting for over 12 hours in the department. Between August 2015 and the time of inspection the department continuously failed to meet national targets to triage patients within 15 minutes. . Some staff told us that they did not always report incidents as they felt nothing would be done about them We found that medical staffing was poor, relying heavily on locum staff and there was limited assurance that the performance of the locum doctors was being reviewed . The establishment of nurses had calculated with some recognition of an appropriate acuity tool. However, a peer review indicated that the number of nurses was lower than required. However We saw examples of patients being treated in a compassionate way, having their privacy respected and dignity maintained while being examined. Patients and relatives spoke in a positive way about the staff in the department. There were safeguarding systems in place to keep people safe. Staff were aware of what types of things to raise as a concern and the procedure for doing this.
Medical care (including older people's care)	Inadequate	We judged medical care services was inadequate because: Incidents were not always investigated in a timely way and staff did not always receive feedback from incidents. Learning was not shared through established systems and channels. Problems with the environment on many of the wards and areas we visited meant that infection control best practice could not always be followed. The Manchester treatment centre was not a suitable environment for patients to stay overnight as there

Summary of findings

were no facilities for them to wash or to store belongings. Intentional rounding was not completed in a timely and effective way. The trust protocol for the use of early warning scores was not always used. Deteriorating patients were not always referred for a medical review deterioration. Staff on the medical emergency unit (MEU) had not received training to use the continuous cardiac monitoring in place on four beds and there was no monitoring system in place at the nurses station. Thickening agent was stored at patient's bed areas without appropriate risk assessments despite a patient safety alert that was issued in 2015.

Patients waited for longer than necessary for beds and more than half of patients were moved once of more during their admission. Patients were moved overnight when necessary although trust policy was that patients should not be moved between 8pm and 8am. Specialist beds on the infectious diseases ward could not be used for their intended purpose because they were filled with medical outliers.

Complaints were not investigated and completed in a timely way. Many leaders at ward level were new in post and their leadership was therefore in its infancy, although staff spoke positively of the changes. Staff told us there was a culture of bullying at some levels and historically, there had been.

However

Nursing staffing levels on medical wards had been assessed using a recognised acuity tool. Fill rates were good for qualified and unqualified nursing staff during the day and at night;. Verbal nursing handovers were comprehensive Care and treatment was provided in line with national guidance from NICE and Royal College of Physicians, the Royal College of nursing and locally produced guidelines

Patients were cared for by staff who were kind, caring and compassionate. Staff respected and upheld patient's privacy and dignity. Friends and family test response rates were high and results were generally positive. Some wards frequently received 100% positive feedback. The trust scored in the top 20% for 25 out of 34 areas on the inpatient cancer experience survey in 2013/14. The trust was performing better than the England average for all four parts of the patient-led

Summary of findings

assessments of the care environment.Communication was sensitive when providing patients with distressing information. Families and loved ones were involved in decisions about care and treatment. There was a good awareness and understanding of patients individual needs. A new system was in place to identify patients with specific needs such as dementia or at risk of falling. There was a dementia nurse consultant and a trust wide dementia strategy and some wards had begun to make changes to the environment to make them more dementia friendly. Staff spoke positively about the chief nurse. She visited the ward regularly and staff felt she was approachable. The divisional manager was visible on the wards and seen daily. There were good relationships with the medical team. There was public and staff engagement in quality monitoring and development of the service.

Surgery **Requires improvement**

We judged surgical services as requires improvement. because
Sepsis management and associated processes were implemented in June 2014. However, since June 2014 there was limited staff uptake in sepsis management training. To-date, 4% of nursing staff had attended this training.
Outliers were located throughout the surgical service. This relates to patients who were situated away from the speciality they should have been admitted to. Concerns were also identified that patients placed on general surgical wards or outliers were not reviewed daily.
Not all staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards, however in the majority of cases consent was taken appropriately.
There were no formal surgical service strategies were not in place.
Newly implemented governance, risk and quality measurement processes were in place, which meant that learning and monitoring processes from governance and quality measurement processes might not be as robust as they should have been.
Some of the staff we spoke with identified that their knowledge of the trust core values and what they involved was limited.

Summary of findings

However
Care was provided in line with NICE CG50. Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.Systems were in place to ensure that risks to elective and emergency patient groups were identified pre-operatively.We observed visibly good infection prevention practices by staff and noted good compliance in this area. Clinical equipment had been serviced. Daily checks of resuscitation equipment had taken place. Consent processes were generally robust and documentation associated with these processes adapted to the individual patient's needs and understanding. The records we reviewed showed that consent was taken correctly. There was good access and flow to services, which met patient's needs. Service developments had improved patient access to treatment.Patients received evidenced based care, treatment and patient outcomes were good. Good multi-disciplinary working existed between the trust, surgical day service, local clinical commissioning groups and community services. Staff were caring, compassionate and respectful.
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Critical care

Good

We have judged the critical care services provided were good because.

- There were systems in place for reporting and learning from incidents.There were sufficient numbers of suitably skilled nursing and medical staff to care for the patient Care and treatment was planned and delivered in accordance with evidence based guidance.Critical care services were delivered by caring, compassionate and committed staff.We saw patients, their relatives and friends being treated with dignity and respect.There was a positive culture with staff and the public being engaged in the development of the service.

However

- It was rare for there to be a supernumerary clinical co-ordinator on duty as set out in the

Summary of findings

national service specification for intensive care (D16).There was a problem with delayed and out of hours discharges.Governance processes were present but yet to be embedded.

Maternity and gynaecology	**Inadequate**		We judged the service as Inadequate because. . · There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm.·There was a failure to effectively investigate and learn from incidents with a lack of openness about outcomes. There was a lack of learning from complaints and a lack of learning and sharing of knowledge from discussions about mortality and morbidity. There was a shortage of midwifery staff which led to some delays in transfers during labour and inductions of labour. Midwives and medical staff were not up to date with training and competence for some of the tasks they performed.There was no emergency gynaecology provision out of hours and no inpatient gynaecology provision at this site. There was a lack of clear systems and processes for managing risks and performance of the service. There were few mechanisms for staff engagement and plans to improve this had not taken place. However Some improvements had been made as a result of the maternity improvement plan including the purchase of necessary equipment. Midwifery and medical staff worked well as a team and provided compassionate care There was an enthusiasm amongst the staff to improve the services. There were changes in the leadership of the service following our inspection. Between the announced and unannounced inspection some practical changes had been made and staff told us there was already an improvement in communication
Services for children and young people	**Inadequate**		We judged that children's services were inadequate because Patient safety was a significant concern. Risks were not escalated appropriately . There were unacceptable delays in the investigation of incidents including those resulting in severe harm. There was a failure to effectively investigate and

learn from incidents. There was a lack of learning from complaints and a lack of learning and sharing of knowledge from discussions about mortality and morbidity.

We found that care and treatment did not always reflect current evidence-based guidance, standards and best practice. Standardised care plans were not in place. Several policies and procedures were not up to date.

Patients received care from staff that did not have the skills or experience that is needed to deliver effective care. We found that the needs of the local population were not fully understood when planning this service particularly when considering the number of under two's that would access the children's wards. On the paediatric ward the number of nurses that were planned for each shift did not meet recommended ratios in 95% of the shifts we reviewed. Some people are not able to access services for treatment when they need to. Over one month 21 patients were transferred to other hospitals to receive their care

There was significant concern regarding how well led the service was. The delivery of high quality care was not assured by the leadership, governance or culture in place.

However

On the neonatal unit staff interactions were positive and babies were treated with kindness and compassion. In paediatrics we saw staff engaging with children and their parents kindly. Parents and carers were, in the main, positive about the care and treatment provided.

End of life care

Good

Overall we judged the service as Good because.

Incident reporting systems were in place and learning from incidents was discussed We saw assessment information from occupational therapy and physiotherapy and good comprehensive nursing assessments in the records. Appropriate risk assessments were in place. The service had developed an individual plan of care and support for the dying person (IPOC) to guide care and support documentation in the last days of life in line with current evidence-based guidance and best practice. There was an audit plan in place and the

reports we saw included appropriate recommendations and action plans to address the delivery of care where standards were not met. The service held a weekly multi-disciplinary team (MDT) meeting where cases and new referrals were discussed. End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill

However

·The rapid transfer process was in its infancy and the service was taking steps to put improvements in place. There were numerous new systems in place or in planning to improve the provision of EOLC including the new steering group, the new reporting operational policy and the proposals for a new bereavement service, seven day working and an electronic palliative care co-ordination system (EPaCCs). · Some patients were not prescribed all of the recommended anticipatory end of life medications. There was no seven day service in place and although the potential risks of the impact on patients had been identified, assurance around the management of these risks was not clear.

Outpatients and diagnostic imaging

Good

We judged the service as Good because

· Mandatory training levels were good and the environment was visibly clean and tidy. Equipment was checked regularly and there was evidence to support this. Staff knew how to report incidents and the learning from these incidents was followed up through regular staff meetings. ·

· Staff were using national guidelines which were being reviewed for compliance by the trust. There were good opportunities for staff development and evidence of effective multi-disciplinary team working. Leadership was good at an operational level in both OPD and radiology and information was shared at all levels in the division; however some allied health professionals were unhappy with the lack of leadership for their professions in the trust.

· Pathology services were efficient with patient blood test results being available during clinics. The service was provided a 24 hour, seven day per week service.

Summary of findings

However

· The did not attend for appointment (DNA) rates in OPD were higher than the England average and the trust did not have anything in place to address this. DNA rates were also high in the radiology department.

· There were issues around the storage of medicines in OPD clinics but the trust were working to change this with pharmacy colleagues.

North Manchester General Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to North Manchester General Hospital

North Manchester General Hospital is situated in Crumpsall Manchester. North Manchester General Hospital is one of the four acute hospitals that form part of Pennine Acute Hospitals NHS Trust, which looks after a population of approximately 820,000 people. There are approximately 481 inpatient beds on the site

The hospital hosts an Accident and Emergency department. Medical care services at the hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology serving the North of Greater Manchester. The surgical services carry out a range of surgical procedures such as trauma and orthopaedics, urology, ear, nose and throat and general surgery (such as gastro-intestinal surgery). The critical care services at the hospital provides care for up 12 patients that flex between level 2 (high dependancy) and level 3 (intensive care) patients with the maxium number of level 3 patients that can be cared for at one time being 7. Maternity and gynaecology services provided at North Manchester General Hospital included offering pregnant women and their families antenatal, delivery and postnatal care. The department delivered approximately 4540 babies every year. A range of gynaecology services and termination of pregnancies was also provided. Paediatric services provided at North Manchester General Hospital, include a 19-cot neonatal unit based on the ground floor of the Women's unit.

Most other services for children and young people under 16 are provided from the paediatric ward and in the Koala unit. The ward consists of 27 inpatient beds, one of which is a designated HDU bed.).

The trust specialist palliative and end of life care service is part of the out of hospitals directorate within the integrated and community services division of the Pennine Acute Hospitals NHS Trust. The service operates across four hospital sites (Fairfield General Hospital, North Manchester General Hospital, Rochdale Infirmary and Royal Oldham Hospital) and in the community in North Manchester. The service operates from Monday to Friday, 8.30am to 4.30pm.

There are no dedicated EOLC beds at the hospital. Between April 2014 and March 2015 there were 820 deaths at the hospital, an average of 68 per month. Figures to date this year are similar, with an average of 67 per month between April 2015 and February 2016.

There is no hospice in Manchester however the SPC team have close links with St Ann's hospice in Little Hulton, Dr Kershaw's hospice in Oldham and Springhill hospice in Rochdale.

The main out-patients department at North Manchester General Hospital (NMGH) was based in the newer part of the hospital with two clinics in standalone buildings in the hospital grounds.

Detailed findings

There was a radiology department with computed tomography (CT) and magnetic resonance imaging (MRI) and an x-ray department. The department also provided ultrasound (obstetric and non-obstetric), breast radiology and interventional radiology services and interventional radiology. There was also a department of nuclear medicine. Haematology and biochemistry services were provided by the onsite pathology laboratory for both in-patients and out-patients. We inspected the hospital as part of the comprehensive inspection of Pennine Acute Hospitals Trust

Our inspection team

Our inspection team for the Trust was led by:

Chair: Paul Morrin, Director of Integration at Leeds Community Healthcare NHS Trust

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two CQC inspection managers, sixteen CQC inspectors, two CQC analysts, a CQC inspection planner and a variety of specialists including: Consultant anaesthetist, Consultant physician; Consultant Upper GI and Bariatric Surgery, Consultant in palliative care, Consultant Paediatrician, Director of Nursing and quality, Lead Nurse in Critical Care & Trauma Senior Independent Hospital Director, Radiology Manager, Pharmacist, senior midwife an experts by experience (lay members who have experience of care and are able to represent the patients voice).

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following core services at North Manchester General Hospital

- Urgent and Emergency Department
- Medical care including care for Older people
- Surgical care
- Critical Care
- Maternity and Gynaecology
- Children and Young People
- End of Life
- Outpatients and Diagnostic Imaging Services

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from the ward areas and outpatient services we visited. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We received feedback through focus groups. We held a listening event on 17 February 2016 where members of the public were invited to discuss their experience of services at North Manchester General Hospital We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at North Manchester General Hospital

Facts and data about North Manchester General Hospital

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

Between June 2014 to July 2015, there were 35,825 surgical spells trust wide serving a population of around 350,000 people 27% of surgical stays were emergencies, 58% were day cases and 17% were elective.

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

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

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

Detailed findings

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

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

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- Critical Care

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There are a total of 481 beds at the hospital and serves a population of 820,000 people. Between June 2014 to July 2015, there were 35,825 surgical spells trust wide serving a population of around 350,000 people 27% of surgical stays were emergencies, 58% were day cases and 17% were elective.

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Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency care services for North Manchester General Hospital sits within the medicine division of The Pennine Acute Hospitals NHS Trust (the trust). The trust provides general and specialist hospital services to around 820,000 residents across the north east of Greater Manchester in Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham, Rochdale and parts of East Lancashire.

The accident and emergency department is open 24 hours a day, seven days a week. The department had separate waiting areas for adults and children. In the majors area of the department there were 13 cubicles and the resuscitation area had five assessment cubicles. There was also a minors area which had 14 cubicles. There was also a separate area for children which had eight assessment cubicles.

A designated room was provided for the assessment and treatment of people with mental health complaints. The department was supported 24 hours a day by the rapid, assessment, interface and discharge team (RAID).

There was access to x-ray and computerised tomography (CT) facilities 24 hours a day, 7 days a week. There was also access to general practitioner (GP) services within the department.

As part of the inspection we spoke to patients and relatives, we observed the daily practice of staff providing care and treatment to patients, and reviewed patient records.

We also spoke with a range of staff from various grades including managers, nurses, doctors and consultants. Prior to, and following the inspection we reviewed further information provided by the trust.

Urgent and emergency services

Summary of findings

We have rated emergency and urgent services as "inadequate" overall. This is because;

- The department had continuously failed to meet the department of health target to see, treat, discharge or admit 95% of patients within 4 hours. Records showed that between July and November 2015, performance had continually deteriorated.
- There were a high number of patients waiting for over 12 hours in the department. As a result of the trust's decision to admit policy these were not always recorded appropriately, limiting the ability to improve the service.
- Between August 2015 and the time of inspection the department continuously failed to meet national targets to triage patients within 15 minutes. In January 2016 this target had only been met on 45% of occasions.
- Some staff told us that they did not always report incidents as they felt nothing would be done about them and that they had not always received feedback when they had been completed.
- The design and layout of the department was restricted and did not always meet the needs of the types of service provided. For example, there was no separate triage area for patients being brought in by ambulance.
- We saw a number of occasions when patients were put back in the waiting area without having any observations done as part of the initial assessment. This meant that deteriorating patients may not always be identified in a timely manner.
- We found that medical staffing was poor, relying heavily on locum staff and there was limited assurance that the performance of the locum doctors was being reviewed so that improvements to performance could be made.
- The establishment of nurses had been calculated with some recognition of an appropriate acuity tool but a peer review indicated that the number of nurses was lower than required.
- We found that the department did not provide support to staff on a regular basis in that only 50.8% of appraisals for nursing staff had been completed.
- Compliance with resuscitation training was low, potentially leaving some staff without the competence or up to date skills to provide resuscitation if needed.
- There were lengthy delays in responding to complaints with some taking between 160 and 283 days to respond to but the trust's policy stated that complaints should be dealt with in between 28 and 60 days.

However;

- We saw examples of patients being treated in a compassionate way, having their privacy respected and dignity maintained while being examined. Patients and relatives spoke in a positive way about the staff in the department.
- There were safeguarding systems in place to keep people safe. Staff were aware of what types of things to raise as a concern and the procedure for doing this.
- A clear leadership structure had been recently implemented for both the division of medicine and for the department.
- A service improvement plan had been developed. This had acknowledged that improvements needed to be made throughout the department and actions had been implemented to reflect these.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

We rated urgent and emergency services as 'Inadequate' for Safe because;

- Some staff said that they did not always report incidents because they felt that little was done when they reported them. When staff did report incidents they told us that they did not always receive feedback.
- There were occasions when we had to prompt members of staff to report incidents for things such as equipment that was overdue a service, inappropriately stored drugs and out of date disposable equipment. Staff did not demonstrate an awareness that these needed to be reported and required several prompts throughout the inspection to report incidents.
- We reviewed rotas for November and December 2015 and found that there was a shortfall in the planned establishment on a number of occasions.
- There were low levels of training in basic paediatric life support, immediate life support for adults and children, advanced life support for adults and children, and safeguarding level 3 for adults and children.
- Resuscitation trolleys were not available in all areas of the department, such as the minors area. When resuscitation equipment was in place, it wasn't always checked as required.
- There were occasions when controlled drugs were administered but not recorded appropriately.
- We found that medical staffing was poor, relying heavily on locum staff and there was limited assurance that the performance of the locum doctors was being reviewed so that improvements to performance could be made.
- The calculated establishment of nurses had been done with some recognition of an appropriate acuity tool. However, a peer review on staffing indicated that the number of nurses needed increasing. This was corroborated by the need to use bank and agency nurses on a regular basis to fill shortfalls.
- Compliance with resuscitation training was low, potentially leaving some nursing staff without the competence or up to date skills to provide resuscitation if needed.
- Between August 2015 and the time of inspection the department continuously failed to meet national targets to triage patients within 15 minutes. In January 2016, this target had only been met on 45% of occasions.
- We saw a number of occasions when patients were put back in the waiting area without having any observations done as part of the initial assessment. This meant that poorly patients would not always be identified in a timely manner.
- High acuity patients were often managed in inappropriate areas, such as the minor injuries area, and there was an incident where a patient requiring resuscitation was managed in a cubicle because there was no room in the resuscitation area.
- We found that the department had not reported all serious incidents in line with the serious incident framework set out by NHS England as a result of the trust policy for the decision to admit. This meant that data showing the number of patients who waited in the department for over 12 hours were not recorded or investigated appropriately on a consistent basis.

However,

- All areas of the department were visibly clean, with no reported occurrences of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (CDIFF).
- There were safeguarding systems in place to protect patients from abuse. Staff were aware of what types of things to raise as a concern and the procedure for doing this.
- The department had up to date major incident and business contingency plans that were accessible to staff.

Incidents

- A trust-wide policy for incident reporting was in place and could be located on the intranet.
- The trust used an electronic incident reporting system and whilst the majority of staff could use it, we spoke to one locum member of staff who was unclear about how to access it.
- The majority of staff could identify the types of incidents that should be recorded. However, this was mixed and during the inspection there were occasions when we had to prompt members of staff to report incidents for things such as equipment that was overdue a service,

inappropriately stored drugs and out of date disposable equipment. Staff did not demonstrate an awareness that these needed to be reported and required several prompts throughout the inspection to report incidents.

- Staff gave us examples of incidents they had reported. However, some staff said that they did not always report incidents because they felt that little was done when they reported them.
- When incidents were reported, we were told that feedback was mandated as part of the reporting process. However, a number of staff told us that they did not always receive feedback.
- Between August 2015 and November 2015 the department had reported a total of 197 incidents. The majority of these related to violence and aggression or security issues. However, there were also incidents about overcrowding, long ambulance waits and staffing problems.
- Between January 2015 and January 2016, the department had reported 31 serious incidents in line with the Serious Incident framework set out by NHS England. The majority of these were as a result of patients being in the department for over 12 hours. However, there were seven occasions that were as a result of clinical incidents.
- All serious incidents were investigated using a root cause analysis (RCA) approach. However, we saw that RCA's were not always completed in a timely manner. For example, the trust had set completion dates of October 2015 for two serious incidents that happened in July 2015 but both of these were still open at the time of inspection in February 2016. Extended completion periods had been agreed for these and initial actions had been put in place.
- We reviewed minutes of senior team meetings which made mention of incidents that had been reported and on one occasion highlighted a backlog of incidents that had not been investigated. However, we did not see any evidence of lessons learnt being disseminated to staff in the department. This was supported by our discussions with staff at the time of the inspection.
- Security were occasionally involved when patients were abusive and this was always recorded through the incident reporting system. However, we were not assured that this was monitored effectively which meant that the appropriateness of these responses may not have been measured.
- We were told that mortality and morbidity meetings were facilitated at divisional level but there were no minutes to confirm this and no evidence of actions or work streams that had been identified to improve. Not all cases of mortality were reviewed at the time of the inspection and this had been identified as an area for improvement so that lessons could be learnt as a result.
- Staff had a general understanding of the duty of candour. We saw evidence that duty of candour was instigated in all of the serious incidents we reviewed. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- All areas of the department were visibly clean and tidy. Equipment and mattresses were visibly clean and free of rips. There was clean linen available for patients and we saw this being changed when needed.
- The trust used an external company to provide housekeeping services. There was no official daily checklist in place to indicate when cleaning had taken place. However, there were cleaners in the department at the time of inspection.
- Between January 2015 and the time of inspection the department had not reported any incidents of patients in the department developing methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C.diff).
- Infectious diseases such as Ebola were screened during the booking in process and there was a set protocol to manage a patient with a suspected infectious disease. There was appropriate personal protective equipment in the triage room for staff to use if they felt that a patient needed isolating following triage.
- There were side cubicles for patients to use in the department. We saw staff using these appropriately for a patient with diarrhoea and vomiting which was potentially contagious or a risk to other patients.
- Staff had regard for and adhered to current infection prevention and control guidelines such as 'bare below the elbow'. We observed staff using appropriate

hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care. Hand gel was available at all entry and exit points as well as in individual cubicles.

- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. However, we saw that on one occasion a sharps box was left open in the minors area and a bio bin with used intravenous fluid bags and giving sets was stored in the clinical room (this room was a clean space for things such as drawing up medication). We also saw in the sluice room that there were a number of sealed sharps boxes from up to three days beforehand that should have been removed.
- Cleaning equipment was found to be accessible and stored appropriately.
- The department recorded results of the patient led assessment of the care environment (PLACE) which scored how suitable and clean patents thought the department was. Between April and October 2015, the department scored a monthly average of 91.46%
- In the 2014 CQC Accident and Emergency survey, the trust scored 8.5 out of 10 when patients were asked how clean they thought the department was. However, this was not trust wide and could not be disaggregated specifically for North Manchester General Hospital or the department.

Environment and equipment

- The department was generally well maintained and visibly clear of hazards. Equipment was stored appropriately.
- Patient cubicles did not always provide a clear line of sight for staff to monitor patients in the majors and minors area of the department. This meant that staff had to ensure that certain cubicles were used for high risk patients or if they required close monitoring.
- There were lockable doors leading to the children's department. However, we found that the doors were always left unlocked meaning that members of public were able to access the children's waiting area and staff were not able to ensure that unauthorised persons did not enter. This risk was partly mitigated by reception staff being able to monitor who entered and left the department.
- Resuscitation trolleys were not available in all areas of the department. For example, there was no trolley in the minors area despite being told that high acuity patients were regularly managed in this area due to access and flow issues.
- We found several pieces of equipment that were out of date on two resuscitation trolleys (one in the paediatric area and one for adults in the resuscitation area), such as guedel airways and defibrillation pads. Expiry dates for these varied between January 2014 and February 2016. We prompted staff to report this as an incident as they weren't aware that it needed to be done.
- We looked at how resuscitation trolleys were checked as part of the unannounced inspection and records indicated that between 1 March 2016 and 17 March 2016 checks had not been completed on five occasions for the trolley in the resuscitation area and seven occasions for the trolley in the paediatric area. Staff told us that there was not always time to complete this and that they could not be checked in the paediatric area if the cubicle where the equipment was stored was being used for treatment. We prompted staff to report this as an incident as they weren't aware that it needed to be done.
- The paediatric resuscitation trolley was located in a side room in the children's department and could potentially be accessed by members of the public when left unsupervised. This was compounded by the fact that the trolley did not have a tamper seal in place to indicate that it had not been used or tampered with since it was last checked. Because of its location, we were also concerned as to how accessible this would be in an emergency situation if the cubicle was being used for care and treatment of another patient.
- Daily checklists relating to the environment and equipment were in place and staff planned to complete this three times per day for all areas of the department. We were told this was to ensure that the environment was appropriate and the equipment was available and safe. However, this was not always done. For example, in the resuscitation area 17 out of 27 checks leading up to the time of inspection were incomplete. We prompted staff to report this as an incident as they weren't aware that it needed to be done.
- Disposable equipment, such as oxygen tubes, masks and cannulas were stored in the main store cupboard in

the department. We sampled a range of equipment which we found to be in date and packaged appropriately. However, this room was unlocked and accessible to patients.
- There was an up to date policy for the safe use and maintenance of medical equipment and there was a central electronic bio-medical engineering department (EBME) that were responsible for their maintenance.
- We checked a sample of electrical equipment and found that they had all been serviced appropriately and portable appliance tests (PAT) had been carried out.
- The paediatric waiting room was separated from the main department. However, we found that it was not access-controlled and all members of the public could gain entry which presented a risk of children leaving the department or abduction.
- The department had a secure room for the assessment of people with mental health disorders. The room had been commissioned to comply with the Royal College of Psychiatry safety requirements.
- There was an on-site security team 24 hours per day. At the time of inspection, we observed them in the department supervising a patient at the request of the nursing staff.

Medicines

- Medicines including controlled drugs were stored securely in line with legislation.
- Staff carried out checks on controlled drugs to ensure compliance with their medicines policy and records indicated that checks were completed correctly on the majority of occasions. However, we saw five instances between the start of February 2016 and the time of the inspection where records indicated that the daily controlled drugs checks had not been completed.
- We also found that between January 2016 and the time of the inspection there were 11 occasions that controlled drugs were administered and not recorded appropriately. For example, there were occasions when two members of staff had not signed the book and there were occasions where the quantity of the drug administered was not recorded. We prompted staff to report this as an incident as they weren't aware that it needed to be done.
- We saw that medication was in date and stored appropriately.
- Medicines requiring cool storage at temperatures between two and eight degrees centigrade were appropriately stored in fridges. Fridge temperatures across the department were found to be in the correct range. However, in a two week period records indicated that daily checks had been missed on three occasions. We prompted staff to report this as an incident as they weren't aware that it needed to be done.
- We checked a sample of patient medication charts which had been correctly documented and signed for.
- The department had a locked clinical room for preparing drugs to ensure that they did not become contaminated and sharps were being used in a safe environment. However, on one occasion we saw a member of staff preparing drugs for administration in a general area within the department.
- Pharmacy staff were responsible for maintaining stock levels across the department on a daily basis.
- Electronic prescribing was in place for patients who were being treated in the department but we were told that the IT system that was used for the rest of the hospital was not used in the department, so it was important to ensure that a full handover was given and that documentation was completed if a patient was admitted to a ward.

Records

- The department used a combination of paper and electronic records.
- We found that paper records were stored at open staff stations in the department and were not securely locked away.
- We checked a sample of 17 patient records and found them to be clear legible and up to date. However, we saw that early warning scores (EWS) or paediatric observation priority scores (POPS) were not completed on four occasions.
- A limited number of pro-formas could be printed from the IT system and could be added to a patient's records. These included things such as a discharge checklist and a mental health assessment form.
- Records were mainly completed with the use of free text but we did see evidence of treatment plans being formulated and documented appropriately.
- We saw that comfort rounding sheets had been completed and that skin bundles had been started for patients who had been in the department for an

extended period of time. Comfort rounding was completed to ensure that patients were re-assessed on an hourly basis and skin bundles were used to assess the risk of pressure ulcers.
- The department had not undertaken any audits of records at the time of the inspection and it was unclear how managers were assured that they were of the correct standard.

Safeguarding

- The trust had an up to date safeguarding policy in place that was located on the intranet and staff knew how to find it.
- The trust had a designated safeguarding lead and there was a safeguarding team based in the hospital who were available for support during normal working hours.
- Senior staff in the paediatric department completed a review of case notes to identify any concerns about missed opportunities for safeguarding. This review was to highlight retrospective information sharing opportunities that had been missed. However, staff told us that they did not receive feedback from this process which restricted any improvements being made.
- Staff gave examples of what a safeguarding concern could involve and were able to describe what actions they had taken in cases of suspected abuse.
- There was an electronic flagging system in place that identified vulnerable children to staff. Information was also shared from departments throughout the trust and information could be added to the hospital system by social services when needed. However, the same flagging system was not in place for vulnerable adults.
- There were clear protocols to follow in the event of a safeguarding concern outside of normal working hours and contact details were available for staff to use at all times.
- Safeguarding training was provided as part of the mandatory training programme. Data provided by the trust showed 79% of nursing staff in the department were up to date with level 2 safeguarding training for children and adults against a trust target of 85%. However, compliance with safeguarding level 3 training was low. Only 43% of identified staff were up to date with training for adults and 50% were up to date with training for children.

Mandatory training

- Mandatory training was delivered in two ways, either by e-learning, which was accessible to all staff on the intranet or through face-to-face learning.
- There was a practice development lead based in the department who was responsible for monitoring mandatory training and personal development review completion for nursing staff.
- We observed a database which listed all nursing staff, highlighting whether they were up to date with relevant training.
- The trust provided statutory and mandatory training. Statutory training had to be completed on a yearly basis and included modules such as information governance, hand washing and fire awareness. Mandatory training had additional modules with differing timescales for completion of individual modules.
- The overall compliance with statutory training was 90% at the time of the inspection, against a trust target of 85%.
- Performance was mixed for some mandatory training modules. For example, 80% of staff were up to date with basic adult life support (BLS) training but only 48% of staff had completed basic paediatric life support (PLS) training.
- Some training had been identified for only band 6 staff and above to complete. For example, 13 members of staff had been identified to complete immediate life support for adults (ILS) and children (IPLS). Only 23% of these staff were up to date with ILS and only 8% with IPLS at the time of the inspection. In addition, 17 members of staff had been identified to complete advanced adult life support (ALS) and advanced paediatric life support (APLS) training. Only 47% of these staff were up to date with ALS and 53% with APLS at the time of the inspection.
- Compliance with mandatory training was highlighted on the divisional risk register as an area of concern as it was difficult to release staff from the department.

Assessing and responding to patient risk

- Guidance issued by the Royal College of Emergency Medicine in 2011 recommends that rapid initial assessment (triage) of patients should take place within 15 minutes of arrival. The department continuously failed to meet the national target for 95% of patients

between January 2015 and January 2016. Performance had deteriorated between April 2015 when it was met for 68.34% of patients and January 2016 when it had been met for 45.44%.

- The service continuously failed to meet the Department of Health 1 hour target which measured the median average time of arrival to the start of definitive treatment between August 2015 and the time of inspection. In this period, the average time that patients waited was between 70 and 95 minutes which was higher than the national average.
- The department used different tools to triage patients and assess their clinical condition. These included the Manchester Triage System (MTS), an early warning score (EWS) system, a patient observation priority (POPS) score and a sepsis indicator warning system.
- The MTS tool aims to reduce risk through triage, ensuring patients were seen in order of clinical priority and not in order of attendance. We saw evidence of MTS being used to triage patients and patients being given a priority score.
- The EWS and POPS systems used clinical observations within set parameters to determine how unwell a patient was. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others.
- EWS and POPS scores were required as part of the patient's initial assessment, and at intervals for routine monitoring for example every two hours. However, we saw three occasions where EWS and POPS scores were not documented at triage and observations were not done.
- There was a sepsis tool used at triage to identify potentially septic patients if they had two abnormal basic observations such as a high temperature and a fast pulse rate. We looked at the records of one patient and saw that no initial observations were recorded and they waited a further 87 minutes from the time of triage for any observations to be done. When they were done, the results triggered the sepsis pathway but this potentially could have been identified earlier and led to earlier intervention had the observations been done on triage.
- We spoke to one member of nursing staff about the sepsis process who told us that they used their clinical judgement to decide whether to escalate patients for doctor review when the clinical parameters for potential sepsis were met. However, it was unclear whether nurses were trained to make such judgements and whether all patients would be referred to a doctor appropriately as a result.
- The department had an escalation plan in place. However, it was last updated in 2013 and we were told that it was under review at the time of the inspection. The escalation plan that was being used reflected some of the current risks that were present in the department such as long waits for before triage. However, there were risks that were not reflected, such as overcrowding in the waiting room, the minors area being used inappropriately or actions to be taken if the department was full.
- We were told by staff that high acuity patients were often managed in the minor injuries area which at times was inappropriate because of their condition. At the time of the inspection we saw several patients being managed in this area due to capacity issues. We reviewed a sample of incident reports and found an incident report from November 2015 that was made by a health care assistant stating that poorly patients were being looked after in this area without a registered nurse being present. Despite this being escalated, nothing was done as there was no bed capacity for the patients to be moved.
- We also reviewed a sample of departmental senior team meeting minutes and found that there had been a number of serious incidents following patients being managed in an inappropriate area of the department. For example, a patient attended requiring immediate treatment but this was delayed due to capacity issues in the resuscitation area. As a result, the patient was managed in a cubicle, which may not have been best suited to their needs.
- Call bells, which were used to alert staff if patients needed attention, were not available in all cubicles. There were four cubicles in the minor injuries area without call bells and there was one side room in the majors area that only had a button on the wall which it was out of reach of patients with restricted mobility.
- In the cubicles where call bells were available, we saw seven occasions where patients had not been given them. On one occasion this was for a patient who had restricted mobility and had been placed in a cubicle

that could not be observed from the main staffing area, which meant that they would have been unable to seek attention if needed. Staff rectified this immediately when we raised the concern.

- The resuscitation area was very cramped and became overcrowded when full. We saw an example of a patient being brought in requiring resuscitation and there was no space to accommodate them. As a result a patient had to be moved on to the corridor while they were treated.
- There was a concern about how patients who arrived in the department by ambulance with a pre-alert were managed. Pre-alerts were used so that the hospital could ensure that an appropriate member of staff was available to treat a patient when they arrived. We saw one patient who was brought in by ambulance with a pre-alert as the ambulance crew considered them to have sepsis. On arrival they were directed to the resuscitation area but had to wait for over 30 minutes for a member of staff to take a handover for the patient.
- On another occasion we saw a patient being brought in by ambulance. A member of nursing staff completed observations for the patient but we later found out that they hadn't been booked in. This provided a risk to the patient in that there was no documented information available for them and staff would be unaware of any potential issues. We raised this with a member of staff who arranged for the patient's details to be added to the system.
- The department used a small number of risk assessments which were included as part of a patients file such as venous thromboembolism (VTE).
- A skin bundle which assessed patients for pressure ulcers and a comfort rounding check had just been introduced prior to the inspection. Comfort rounding is a system that prompts staff to assess the needs of a patient on an hourly basis. These were important as patients were spending a large amount of time in the department. Staff told us that prior to these being introduced, they would 'do their best' in managing patients. However, they did not have anything formal to follow.
- Some risk assessments were not available such as a falls assessment. We were told that this was under review at the time of the inspection. Between August and November 2015, ten falls had been reported as incidents by the department. However, only one of these had resulted in harm to the patient.
- We were told by reception staff that although there was no formal training process in place, they relied on 'experience' in recognising patients who needed assistance and were able to give us examples of patients whom they would notify nursing staff of immediately.
- Between August 2015 and January 2016 the department recorded 456 'black breaches'. A black breach is when an ambulance crew is waiting for over an hour to hand over their patient to staff in the department.

Nursing staffing

- The required nursing establishment had been calculated as part of the division of medicine. A report had been completed in June 2015 which had taken some consideration of the safer staffing guidelines produced by the National Institute for Health and Care Excellence (NICE).
- The last recruitment drive was held in August 2015 and that the department had recruited newly qualified nurses. Against the calculated establishment there was currently only one band 6 nursing vacancy.
- However, in January 2016 a neighbouring trust undertook a peer review to assess if the current staffing establishment for the department was appropriate. The findings of the report stated that the nursing establishment should be uplifted by a minimum of 10 whole time equivalent (WTE) band 5 nurses. This report had only just become available at the time of the inspection so there had not been any actions taken.
- We saw that at the time of inspection the department was fully staffed in regard to their calculated establishment. However, we checked rotas between November and December 2015 and found that there were 14 occasions when planned staffing levels of registered nurses had not been achieved.
- In the same period, the planned level of health care assistants were not achieved on nine occasions. The department used health care assistants to support nursing staff with their responsibilities such as completing observations and supporting patients with personal care. The supporting role that they provided was important, especially when registered nurses were busy.
- The use of bank and agency staff was high and they were used on most days to fill vacancies and cover sickness.

- The department had been commissioned to employ three emergency nurse practitioners who were able to see, treat and discharge some patients who attended the department.
- A paediatric advanced practitioner and paediatric nurses were employed by the department. The department always had at least one paediatric nurse on duty at all times which met the royal college of nursing (RCN) guidelines. The department aimed to have three paediatric nurses on every shift. However, this was not always possible and shortfalls were often covered by agency staff who were not paediatric trained.
- We saw that the average sickness rate in the department between May 2015 and December 2015 was 8.96% and had been higher than the trust target of 5% in every month during this period. We were told that this was having an impact on daily staffing levels and was one of the reasons why bank and agency staff were being used regularly.
- There was also a high staff turnover. Records indicated that this was 11.54% for nursing staff at the time of inspection.
- We observed a nurse handover during the inspection. The co-ordinator outlined basic information such as how many patients were in the department to all of the staff. However, there was no evidence of a safety briefing for staff or a forum for any incidents or concerns to be disseminated. Following this, staff then completed a one to one handover for patients they were responsible for.

Medical staffing

- The department had been commissioned for an establishment of nine consultants. Only one of these was employed substantively at the time of the inspection. However, consultants from other areas of the trust worked in the department on a rotational basis to provide support.
- The department had employed two GP specialists. Following consultation with the Royal College of Emergency Medicine (RCEM), it had been agreed that they could be used to fill a consultant role providing that they were supervised by a consultant on-call so that further advice was available if needed.
- There was an advanced nurse practitioner who was the clinical lead for paediatrics. In addition, a paediatric consultant was employed by the department. However, the paediatric consultant did not currently work in the department due to being seconded into another role within the trust.
- There was consultant cover from 8am to 10pm from Monday to Friday and 9am to 5pm at the weekend. Outside of these times there was a consultant on call. There was also access to a 24 hour on-call paediatric consultant if required.
- The department were established for seven middle grade positions and 13 junior doctor positions. However, only three middle grade doctors and five junior doctors were employed substantively at the time of the inspection. As a result, the department relied heavily on locum doctors of all grades. We were told that the department tried to use the same staff on a regular basis so that they were familiar with policies and procedures. The management team told us that the made sure that all locum doctors had the correct level of experience prior to their employment.
- We reviewed medical rotas from the beginning of February 2016 to the time of inspection. We saw that with the daily use of locum staff, planned staffing levels were achieved for consultants and middle grade doctors on all occasions.
- The department was established for four junior doctors in the daytime and two out of hours. However, due to the low number of substantive, staff the department had reduced this to three in the daytime and one at night time. We reviewed rotas covering a four week period during February and found that the newly calculated number of junior doctors had been achieved on all but one occasion with the majority of vacancies being filled with middle grade doctors.
- The department had received funding for additional doctors due to winter pressures. However, we found that these had been filled on only a minority of occasions during the same period.
- All locum doctors received a corporate induction and a formal introduction to the department. However, on one occasion a locum doctor told us that they had received their corporate induction but had not been shown around the department. As a result of this the doctor was unable to find an information leaflet that was needed before discharging a patient and was unable to explain the process that was used for incident reporting.

Urgent and emergency services

- There was limited assurance that the performance of locum doctors was being reviewed on a regular basis. This was important as locum doctors formed a large percentage of the medical workforce within the department.
- Medical handovers were not always facilitated on a daily basis. On one occasion that the senior doctor in the department had to request information from the nursing staff to find out about patients who were currently in the department.
- Records indicated that the average turnover of medical staff was 17.74% at the time of inspection.

Major incident awareness and training

- There was an up to date major incident and contingency plan in place for the department. This was last updated in February 2015.
- There was a major incident file in place which had recently been updated. This had all necessary paperwork in it such as action cards highlighting key roles for staff. However, some staff told us that they were unsure what their roles would be if a major incident occurred and only 45% of staff were up to date with chemical, biological, radiological, nuclear and explosives (CBRNE) training.
- There was a major incident lead in the department who was responsible for the required equipment and supported the provision of appropriate training. The department last held a table-top exercise for a major incident over 12 months ago. A table-top exercise simulates a major incident and how it would be dealt with, providing staff with an understanding of different roles they could be asked to carry out.
- There was a designated cupboard in the department that stored all of the appropriate major incident equipment. Records indicated the equipment had been checked and was in date.
- Staff were trained in the use of dry decontamination as part of CBRNE training and there was a designated area outside of the department for this.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated urgent and emergency services as 'Requires Improvement' for Effective because;

- Only a small amount of appraisals for nursing staff had been completed.
- Newly qualified nursing staff were not always fully supported with an appropriate preceptorship period that allowed them to gain sufficient experience of working in the department before they had the responsibility of looking after patients.
- Results from clinical audits that had been completed in line with the Royal College of Emergency Medicine (RCEM) guidelines were sometimes worse than the national average. We also saw limited evidence of the department using local audits to monitor the effectiveness of the service so that improvements could be made.
- Re-attendance rates were always higher than the England average between January 2015 and January 2016.

However,

- Staff in the department had regard to and provided treatment in line with evidence based practice.
- Staff had access to a limited number of pro-formas which could be found on the IT system and were able to access the trust intranet for guidance covering a large number of injuries and illnesses.
- The department worked with a number of teams, both inside and outside of the hospital including discharge teams and mental health services.
- Access to radiology and pharmacy services were available seven days a week.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence based practice and national guidance such as those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM).

- Both nursing and medical staff within the department were aware of how to obtain guidance for the treatment of specific illnesses or injuries if pathways were not available. This included access to the trust's intranet and guidance provided on the trust-wide website which covered things such as respiratory conditions, toxicology, major trauma and burns as well as head injuries and muscular-skeletal injuries.
- There were pathways available for a small number of conditions such as sepsis or fractured neck of femur that could be added to patient notes when required. However, there was a limited number of care bundles available that could be printed and added to patient documentation for standardisation. Nursing and medical staff used free text on most occasions when completing documentation.
- We saw limited evidence of local audits being completed at departmental level and staff were unable to identify areas of low compliance. For example, the management team were completing audits of safeguarding notes and comfort rounding records. However, the results from these had not been collected so that an action plan highlighting areas of improvement could be formulated.

Pain relief

- The department had access to a variety of medications used for pain management.
- Appropriate pain scoring was used to assess the level of pain for adults and a child friendly pain scoring tool was used to assess pain in children.
- We checked a sample of 17 patient records. We found that all records either had a pain score documented or documentation evidencing that a discussion had taken place about levels of pain.
- When pain relief had been given, a second pain score and reassessment had been completed which measured the efficacy of the medication given.
- Patients and relatives that we spoke to confirmed that pain relief had been given in a timely manner.
- The 2014 CQC accident and emergency survey showed that the trust scored 6 out of 10 when patients and relatives were asked if pain relief was received in a timely manner. This was similar in to other trusts. However, this was trust-wide and could not be disaggregated specifically for North Manchester General Hospital.

Nutrition and hydration

- The department did not use any nutritional assessment tools to assess patients despite them being used in other areas of the hospital. Using this kind of assessment could identify patients who might be at risk of malnutrition and allow for a referral to appropriate professionals for ongoing support.
- The department had introduced the provision of food and drink for patients due to the extended amount of time that was being spent in the department. We saw staff during the inspection provided hot meals as well as drinks and snacks when required.
- A number of extra support staff had recently been recruited to help provide this when needed.
- Food and drinks were available for patients while in the department. Relatives also had access to vending machines which provided cold drinks and snacks.
- Results from the trust-wide 2014 CQC accident and emergency survey showed that the trust scored 5.9 out of 10 for providing suitable food and drink, which was similar to the performance of other trusts. However, this was trust-wide and could not be disaggregated specifically for North Manchester General Hospital.

Patient outcomes

- Unplanned re-attendances to the department within 7 days were monitored on a monthly basis. Between January 2015 and December 2015, the rates of re-attendance were always higher (worse) than the national average of 5%. Performance varied between a low of 7% and a high of 8.5%.
- We saw that the trust had participated in national audits such as those identified by the Royal College of Emergency Medicine (RCEM). The results were used to benchmark and compare with other trusts nationally. There were examples of evidence based audits being completed such as cognitive assessments for older people, management of mental health, sepsis, neutropenic sepsis and management of the fitting child. The trust recognises it requires improvement with regard to managing sepsis however there are monthly audits in place which are part of the trust's sign up to safety programme.
- Results from these audits recorded outcomes based on individual departments and action plans that had been developed were specific to each individual department.

- The department had last undertaken an audit as recommended by RCEM on the management of sepsis in 2011 which highlighted areas for improvement. We did not receive any evidence that this had been either monitored or improved since. In addition, the trust did not participate in the national RCEM audit of sepsis management in 2014. This meant that there was no up to date data that measured the effectiveness of how sepsis was managed in the department.
- The results from a national RCEM audit that had been completed in 2014 for cognitive assessments in older people showed that this trust were worse than those of similar departments nationally. For example, out of 60 patients who attended the department, none had an appropriate cognitive assessment undertaken.
- Results from a national RCEM audit completed in 2015 for the management of mental health in the department showed that there was poor compliance with mental state examinations, which were only carried out in 8% of cases. This was again worse than similar departments nationally. An action plan to improve compliance with this had been implemented. This included developing a pro-forma and putting it on the IT system to remind staff to complete it. However, this had not been re-audited to measure improvement.
- The department took part in a national RCEM audit for the fitting child in 2014. Positively, it showed that children were treated using the correct pathway in all cases. However, we saw that blood glucose levels were checked and monitored correctly in only 67% of cases which was worse than other departments nationally.
- Results from a national RCEM audit of neutropenic sepsis (2015) showed that out of a sample of 21 records, only seven had antibiotics prescribed and administered, complying with the national standard within 1 hour. We saw an action plan had been developed as a result of this, which included the introduction of a sepsis trolley which had pre-prepared equipment available. We saw that the trolley had been introduced as planned at the time of the inspection.

Competent staff

- All nursing and medical staff were required to have an annual appraisal which gave them an opportunity to discuss their achievements and areas for improvement. However, only 33% of these had been completed for nursing staff at the time of inspection. Staff also told us that they had been assigned a named mentor but rarely had the opportunity to speak to them formally.
- Medical and locum staff were required to complete an appraisal as part of their re-validation process.
- There was limited assurance that the performance of locum doctors was being reviewed on a regular basis through clinical supervision. This was important as locum doctors formed a large percentage of the medical workforce within the department.
- There was an induction and a preceptorship plan in place for new staff. This included an eight week supernumerary period for new staff (supernumerary means they were not included in the daily staffing numbers so that they could learn without specifically being assigned patients to care for as an inducted member of staff would). The induction programme included a competency book which was to be completed over a 12 month period. Competencies included things such as intravenous therapy and patient assessment.
- We discussed the preceptorship plan with staff and one member of staff told us that it was not always facilitated as planned. For example, they had only been given a two week supernumerary period despite them raising concerns about this. This was confirmed by a member of the management team who told us that the decision to do this was made because of current demands on the department and that a number of other newly qualified nurses had been put in a similar position.
- One member of the same group of staff expressed concerns that they had been asked to administer intravenous medication without having achieved the competency to do so. A member of the management team also acknowledged this and told us that they had ensured that the correct certification had been provided after the event had occurred. We found no evidence that this had been recorded as a clinical incident or that measures had been put in place to prevent it happening again.
- The department provided a one day training course for staff who were responsible for triaging patients. Following this, staff had further supervision to ensure that correct policies and procedures were followed. However, some staff told us that they had received the one day training but the following period of supervision was not always facilitated.

- There were a number of in-house training days that had been developed for nursing staff. For example, a mental health awareness session had been facilitated and had been well attended. Further training days were available covering topics such as wound care and diabetes. However, some of these had been cancelled due to operational demand.
- Medical staff had training sessions that were rotated on a week by week basis. We were told that agency and locum staff did not have any involvement in staff training days and that this was facilitated by their agencies.
- Some staff had been given the opportunity to develop their knowledge and skills. For example, some had completed training modules in areas such as minor injuries, which could be accessed through university. There were also two emergency practitioners training to be advanced nurse practitioners at the time of the inspection.
- Some support workers had been trained to support nursing staff by undertaking additional tasks, such as blood pressure checks and venepuncture (to take blood).
- There was a trust wide revalidation team who monitored expiry dates of the registration of staff and supported them to revalidate when required.

Multidisciplinary working

- Staff told us that relationships with other departments in the hospital had deteriorated due to the pressures created by the lack of beds and the need to transfer patients out of the department.
- Hospital-wide bed management meetings were held on a daily basis to review the need for patients to be admitted and the availability of beds. We saw bed management staff in the department on a number of occasions during the inspection reviewing patients that required admission.
- The department worked alongside externally commissioned mental health practitioners from the rapid assessment, interface and discharge (RAID) team. This team was based in the hospital and provided 24 hour cover for assessment of adults with mental health concerns.
- The child and adolescent mental health service (CAMHS) was externally commissioned and were accessible when required. However, we were told that they could sometimes take between 4 to 6 hours to attend and patients were managed in the department whilst waiting.
- The department had access to some external services including drugs misuse and alcohol liaison services.
- The department had access to a navigator team between the hours of 8am to 8pm. The navigator team was made up of a team of professionals, such as physiotherapists and occupational therapists, and was designed so that the needs of a patient could be fully assessed before discharge. The navigator team made referrals to community services when required. If a patient was ready for discharge outside of normal working hours they would be managed in the department or admitted until this could be done safely.
- The department had regular communication with the ambulance service to manage demand. For example, if a large number of patients arrived at once, an ambulance liaison officer (ALO) would sometimes be allocated to the hospital to support the management of patients.

Seven-day services

- The department was open to adults and children 24 hours a day, 7 days a week.
- There was consultant cover in the department between 8am and 10pm on Monday to Friday and 9am and 5pm on Saturday and Sunday. Outside of these hours, consultants were available on call.
- There was a middle grade doctor available in the department 24 hours a day.
- A 24 hour radiology service was available within the department which included the provision of x-ray and CT (computerised tomography) scanning facilities.

Access to information

- All staff who worked in the department, including agency and locum staff had access to IT terminals.
- The electronic records system could be accessed throughout the department. There was access to a patient's history and records were scanned on to the system after a patient had been discharged. This meant that if a patient re-attended, staff were able to review previous notes to assist with diagnosis and treatment.
- Results from diagnostic testing such as blood tests and x-rays were added to the electronic system so that they could be reviewed by nursing and medical staff.

- We saw a limited number of pro-formas available on the IT system that staff could print and add to a patient's notes when required such as sepsis pathways.
- We saw that safeguarding information for children was highlighted on admission. However, this system was not available for adults meaning that it was not always ensured that information for vulnerable adults was shared effectively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a trust-wide policy for consent, mental capacity and deprivation of liberty safeguards which was accessible to staff on the intranet. Staff were able to find this policy if it was needed.
- A basic level of mental capacity and deprivation of liberty safeguards training was included as part of safeguarding level 2 training. This was then covered in more detail as part of safeguarding level 3.
- Some nursing staff told us that they did not feel that the level of training provided was adequate and that they were uncomfortable in being able to undertake a formal mental capacity assessment. This meant that a patient would have to be assessed by a doctor or the RAID team for this to be completed.
- Conflict resolution training was provided to staff as part of mandatory training. This could be used to de-escalate patients when needed and we saw that 79% of staff were up to date with this.

Are urgent and emergency services caring?

Good

We rated urgent and emergency services as 'Good' for Caring because;

- We saw examples of patients being treated in a compassionate way, having their privacy respected and dignity maintained while being examined. Patients and relatives spoke in a positive way about the staff in the department.
- We reviewed a sample of patient records during the inspection and saw that treatment had been discussed with the patient including a plan of how their injury or complaint was being managed.
- We saw staff attending to patients in a timely way and despite being very busy they spent as much time as they could supporting patients when needed.
- Comfort rounds had been introduced to ensure that patients were comfortable during their stay in the department.

Compassionate care

- We saw examples of staff treating patients in a kind and compassionate way despite the capacity pressures in the department.
- Patients and relatives spoke highly of the staff that they had come into contact with and described them as 'lovely'.
- We saw that during times of consultation and treatment that staff respected the privacy and preserved the dignity of patients while being examined. This included either closing doors to side rooms or drawing curtains around fully.
- We observed occasions when staff responded quickly to a patient if they required help or if they appeared in discomfort or pain.
- The management team had recently introduced comfort rounds due to patients experiencing an extended delay in the department. This was to assess if a patient was comfortable and to identify any needs that the patient had on an hourly basis.
- In the 2014 CQC Accident and Emergency survey, patients gave the trust a score of 8.6 out of 10 when asked if staff took the time to listen to what you had to say and 8.7 out of 10 when asked if staff talked about you as if you were not there. These scores were similar to those of other trusts. However, this was trust-wide and could not be disaggregated specifically for North Manchester General Hospital.
- The results from the NHS friends and family test between April 2015 and October 2015 showed the trust consistently scored below the England average, indicating that only 81% to 83% of patients were positive about recommending the trust to friends and family. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received.

Understanding and involvement of patients and those close to them

Urgent and emergency services

- We reviewed a sample of case notes and saw that discussions had been documented about a patient's condition and treatment plans. Patients told us that they were pleased with the amount of information that had been given by the nursing and medical staff.
- Staff respected patient's rights to make choices about their care.
- We observed examples of staff spending time discussing issues with a patient and their relatives. Staff were approachable and friendly if patients and relatives had questions or a concern that they wanted to address.
- In the 2014 CQC accident and emergency survey, patients gave the trust a score of 8.6 out of 10 when asked while you were in the department, did a doctor or nurse explain your treatment or condition in a way in which you could understand. A score of 7.4 out of 10 was also given when asked if your family or someone else wanted to talk to a doctor, did they have enough opportunity to do so. Both of these scores were similar to those of other trusts. However, this result was trust-wide and could not be disaggregated specifically for North Manchester General Hospital.

Emotional support

- We saw that both nursing and medical staff were extremely busy during the time of inspection. However, staff made efforts to spend as much time with patients as they could to support them.
- Patients had an allocated nurse who was able to address any concerns or support them with any anxieties that they had.
- The hospital chaplain attended the emergency department when needed and was available to spend time with relatives.
- We saw examples of staff spending time and supporting the families of patients who were poorly.
- In the 2014 CQC Accident and Emergency survey, patients gave the trust 6.1 out of 10 for if you were feeling distressed while in the department, did a member of staff help to reassure you and 7 out of 10 for nurses and doctors discussing any fears and anxieties about your condition or treatment. These scores were about the same as other trusts. However, this was trust-wide and could not be disaggregated specifically for North Manchester General Hospital.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Inadequate

We rated urgent and emergency services as 'inadequate' for responsive because;

- The department had continuously failed to meet national targets to see, treat, discharge or admit patients within 4 hours. Records showed that between July and November 2015, performance had continually deteriorated.
- Records indicated that there had been a high number of patients waiting for over 12 hours in the department. As a result of the trust's decision to admit policy these were not always recorded appropriately potentially providing and inaccurate picture of performance and limiting the ability to improve the service.
- The department had failed to meet the national target for ambulance turnaround times of 30 minutes between August 2015 and January 2016.
- The design and layout of the department was restricted and did not always meet the needs of the types of service provided. For example, there was no separate triage area for patients being brought in by ambulance.
- The design of the department did not always meet the needs of patients in that privacy and dignity could not be ensured.
- The department had taken between 160 and 283 days to respond to a number of official complaints that had been made. This was in comparison to the trust policy which stated that complaints should be dealt with in between 28 and 60 days. There was limited evidence that complaints had been issued to inform learning or service improvement.

However;

- The department had a separate area for children attending the department which included books and toys.
- There were translation services available if needed through the use of a telephone line and a bank of face to face translators. Information including advice leaflets could also be requested in a variety of languages.

- The department had access to general practitioner (GP) services and patients were transferred if their condition allowed.

Service planning and delivery to meet the needs of local people

- The department did not always meet the needs of the people using the service.
- The waiting areas for both adults and children were reasonably sized. However, when there was a high demand on the service, they could become overcrowded quickly.
- The design and layout of the department was restricted and did not always meet the needs of the types of service provided. For example, there was no separate triage area for patients being brought in by ambulance. This led to ambulance staff and patients waiting in corridors and a private area for transferring a patient on to a hospital bed could not always be facilitated unless there was a free assessment cubicle for a patient to go into.
- The department had a designated room for families to use when patients were extremely unwell or in the resuscitation area for example. However, there was only one room and there were no other facilities available to support additional families if needed.
- In addition, the department did not provide a separate area or a viewing room for bereaved relatives. We saw a family not being given privacy when required as they were only able to spend time with their relative in the resuscitation area which at the time was extremely busy with patients and staff. The resuscitation bays had curtains that were drawn around but did not provide the level of privacy that would have been had in a side room.
- There was a general practitioner (GP) service that was based in the outpatients department. Patients presenting at the emergency department were referred to this service between the hours of 8.30am and 10.30pm if their condition allowed.
- There was a separate waiting and triage area for children which had things to keep them entertained such as books and toys.
- An initiative had been developed in the department following a number of attendances because of oral hygiene related complaints. Families were given advice and a dental hygiene pack including a toothbrush and toothpaste with the aim of reducing further similar attendances.
- The department had introduced the provision of food and drink for patients due to the extended amount of time that was being spent in the department. We saw staff during the inspection provided hot meals as well as drinks and snacks when required.

Meeting people's individual needs

- The department had a dementia link nurse and the trust had developed a strategy for supporting patients living with dementia. This strategy had not been fully implemented in the department, for example, there were discreet symbols used to identify patients with dementia. However, the department did not use 'this is me' books which provided invidualised information about each patient.
- Dementia awareness training was provided for staff and records indicated that compliance was 62% at the time of the inspection.
- There weren't any designated or adapted cubicles in the department that could be used for patients living with dementia. Staff told us that they would always try to use an assessment cubicle which allowed the patient to be easily monitored. However, this wasn't always possible due to the high number of patients in the department and the resultant limited space.
- The trust employed a disability nurse who was able to support staff from Monday to Friday during the day. The electronic system had a flagging system which made staff aware that a patient had additional needs. If a patient was admitted with a learning difficulties passport, there was a facility to add this to the electronic system.
- Staff who specialised in dealing with patients with mental health concerns were based in the hospital 24 hours a day. We were told that patients were being seen and assessed in a timely manner.
- The department had access to the child and adolescent mental health team (CAMHS) which was not based on site.

- The hospital had a bereavement team who were able to attend the department and support staff if needed. There was a bereavement resource file that had been designed to support staff when the team were unavailable. However, we found that this file was empty.
- Access to translation services was available for patients and relatives. There was access to a telephone translation service and the trust used a bank of 107 translators who were able to attend if needed. However, staff told us that access to this service was limited. Advice leaflets could also be requested in different languages when required.

Access and flow

- Between November 2014 and November 2015, records indicated that compliance with the Department of Health target of seeing, treating and discharging patients within 4 hours had varied. The department had met the required standard on ten weeks out of 52 during this period. However, performance had continuously deteriorated from July 2015 (93.69%) to November 2015 (77.93%).
- The percentage of patients waiting from between 4 to 12 hours for admission varied. Between November 2014 and June 2015, compliance was similar to the national average. However, between July 2015 and February 2016, performance had dropped and compliance was continuously higher (worse) than the national average. The average wait experienced by patients waiting to be transferred to a ward was between 13 and 17 hours. We saw a number of occasions where patients had been in the department for up to 24 hours.
- The department had reported 3 serious incidents in December 2015, 11 in January 2016 and 33 in February 2016 relating to patients waiting more than 12 hours in the department.
- NHS England guidelines state 'the time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient or the time when treatment that must be carried out in A&E before admission is complete – whichever is the later.'
- The emergency department had historically recorded the decision to admit (DTA) time as decision at the point of referral to speciality. This meant that incidents of patients spending more than 12 hours in the department were not always recorded as serious incidents.
- The department was trialling a process where the DTA time was recorded at the point when the decision to admit was made by the emergency department clinician. This was evident during our unannounced visit. The revised system identified all patients who had spent more than 12 hours in the department which was evidenced by the increased number of serious incidents being reported.
- The department monitored patients who left without being seen on a monthly basis. We saw that between October 2015 and the time of inspection this varied between 5.5% and 7% which was higher (worse) than the national average.
- The department failed to meet the national target for ambulance turnaround times of 30 minutes between August 2015 and January 2016. Trust-wide data showed that monthly averages of ambulance crews waiting between 30 minutes and 60 minutes varied from 40% to 55%. Figures produced by the department showed that during the same period ambulance crews had to wait between 30 and 60 minutes on 901 occasions.
- The management team told us that the main problems with patient flow were due to access and flow issues throughout the hospital. They acknowledged that there were limited systems in place to support patient flow which had been addressed as part of the overall service improvement plan and included initiatives such as using a rapid assessment and triage (RAT) model.
- Patient flow was also hindered by the minor injuries area being used to treat patients who would have normally been managed in the majors area. This restricted the role of both the doctors and nurse practitioners in this area as they were unable to see, treat and discharge appropriate patients in a shorter period of time.
- The department didn't have any holding areas for patients such as a clinical decisions unit or an ambulatory care unit. This meant that patients waiting for admission to the hospital took space that could be used to see and treat another patient.
- We were told that the main reason patients did not see a doctor within an hour was a combination of there not being enough medical staff available and the lack of cubicles for patients to be assessed in due to overall capacity issues.

- The department had an escalation plan that included the use of a secondary triage if the length of wait increased more than 30 minutes. However, this was not always facilitated due to the extra triage room not always being available.

Learning from complaints and concerns

- There was a trust-wide complaints policy in place which was accessible on the intranet. All complaints were managed and monitored centrally by a trust-wide team.
- There were 36 official complaints about the department made between January 2015 and November 2015. We reviewed all of the complaints and the majority of them related to waiting times and dissatisfaction with the level of treatment that had been provided.
- The target was for all complaints to be resolved in 25 days and for more complex cases, to be resolved in 60 days. On most occasions the trust had not met this target. There were 14 occasions when the trust had taken between 106 and 283 days to respond to the complaints fully. We also saw that there were 10 complaints outstanding, some of which dated back to September 2015.
- We reviewed the responses for complaint investigations that had been completed and found that patients and relatives had been provided with information about the result of the complaints.
- Complaints were discussed in senior team meetings. However, we saw no evidence of these being used to inform service improvement. Staff that we spoke to were unable to give us examples of any lessons learned from complaints that had been made.
- Staff knew how to provide information to patients or relatives about how to make formal complaints. Patients also had access to leaflets that described the process for making a formal complaint if required.

Are urgent and emergency services well-led?

Inadequate

We rated emergency and urgent services as 'inadequate' for well led because;

- There was a divisional risk register that highlighted some but not all risks that were currently faced by the department. The escalation plan that was being used did not reflect the current risks for the department and had last been updated in 2013.
- Staffing levels had been calculated but this did not always reflect the need of the department. There had been a peer review of staffing levels carried out that indicated there was a shortfall in the number of staff needed to keep patients safe.
- There was limited evidence of local audits that measured the effectiveness of the service provided and the few that were completed were not used in a way that promoted improvement.
- Staff told us that they did not always feel valued and respected by the management team and that they felt they were under a great deal of pressure due to the demand on the service. This was reflected in the high sickness and staff turnover rates.
- The new leadership team had only been able to respond to the challenges faced by the department three weeks prior to the inspection which meant that there had been a minimal amount of time to make any significant improvement.

However;

- The Trust had a clear vision and strategy and the new management team for the division of medicine had recently implemented a strategy for improvement. A service improvement plan had been implemented with clear ownership and timeframes for actions to be completed.
- There was a clear leadership structure that had been recently implemented. We saw that leaders were visible in the department throughout the inspection.

Vision and strategy for this service

- The trust had a clear vision and strategy that was based on values, was quality driven, responsible and compassionate.
- The department sat within the division of medicine for governance purposes.
- The department had been involved in the 'perfect week' initiative which had been designed and developed by NHS England's emergency and urgent care intensive support team (ECIST) with the aim of identifying key

areas that could be targeted for improvement. Following this, recommendations were made including developing an ambulatory care model and reviewing the discharge process that was currently being used.
- The service were working alongside the Trust Development Authority in order to facilitate rapid improvement events for the service which aimed at providing improvements to the majors, minors and paediatrics areas of the department.
- Following these events, the new divisional team had formulated a strategy to improve the service through the implementation of an urgent care improvement plan which had recently been developed. This highlighted key areas such as staffing, access and flow issues and the development of multi-disciplinary team meetings. There was also a plan in place to support poor access and flow by revising the trust decision to admit policy and the introduction of a separate ward that can be used for patients waiting for admission. This plan had been developed with target dates set for completion so that progress was being measured.
- Staff could identify some parts of what both the divisional and trust wide team were aiming to achieve. However, the plans had only been in place for a short period of time and not much of it had been implemented at the time of the inspection.

Governance, risk management and quality measurement

- The division of medicine used a risk register to monitor and manage risks. This register included all departmental risks. Examples of risks identified included high sickness levels, low levels of compliance with performance targets, failure to comply with mandatory training requirements and a lack of systems being in place to ensure patient safety. Management within the division were able to identify the main issues that they currently faced. Actions were listed against these risks and were due to be completed by the end of March 2016. However, it was unclear if actions had been taken to lower risk in a timely way as some risks had been present on the register since 2011.
- The department had an escalation plan that they followed. However, this plan had not been reviewed since 2013 and we were told by the management team that it was currently being reviewed.
- The escalation plan reflected some of the current risks that were present in the department such as long waits for before triage. However, there were current risks that were not reflected, such as overcrowding in the waiting room, the minors area being used inappropriately or actions to be taken if the department was full.
- The department had a risk assessment file which covered things such as violence and aggression within the department, manual handling and infection control. We saw that these had been signed by a member of the departmental management team but it was unclear if they had been reviewed through any governance processes.
- Staffing levels had been calculated for the department under the division of medicine. However, this did not reflect the demands that the department faced. As a result there were staffing shortages, high sickness rates and a heavy reliance on bank and agency nursing staff as well as locum doctors. The trust had commissioned an external peer review of staffing to identify areas for improvement but this had only just been concluded at the time of the inspection and no actions had been taken.
- The division of medicine held a quality and performance meeting every two weeks. These meetings were attended by representatives from the department and included topics such as patient safety, experience and performance monitoring. The department also held a weekly senior meeting that reviewed issues about the department such as incidents, complaints and patient care.
- We found there to be a lack of communication between the department and staff from teams within the hospital. There was currently limited provision for multi-disciplinary team (MDT) meetings to discuss access and flow through the hospital.
- Staff told us that findings and lessons learnt from incidents and complaints were not always fed back to prevent recurrence.
- Minutes from senior team meetings highlighted that there was a backlog in dealing with incidents. However, there was evidence that outstanding incidents had been prioritised and more serious incidents had been investigated in a timely manner. There were also two serious incident investigations in progress. These had completion dates of October 2015 but they had not been completed at the time of the inspection in February 2016. However, extended time frames had been agreed.

- We saw that as a result of the trusts decision to admit policy that not all serious incidents had been reported as required by the serious incident framework which was set out by NHS England. However, this policy was reviewed by the trust following the announced part of the inspection and had been changed when we returned on the unannounced element of the inspection and as a result we saw an increase in the number of serious incidents being reported.
- Quality measurement in the service was limited. The department did not undertake regular local clinical audits to assess the quality of care and treatment provided. The trust wide audit team completed clinical audits that measured the effectiveness of care and treatment. However, staff were unable to give us examples of areas of low compliance.
- The management team had introduced a number of daily checks two weeks prior to the inspection. This included cubicle checklists, a review of missed information sharing opportunities for safeguarding and the introduction of comfort rounding logs into patient records. These were aimed at improving the quality of service provided but there was currently no measurement of how effective this had been.

Leadership of service

- The leadership for the division of medicine had a clear structure. However, this had only been implemented three months before the inspection. There was a divisional medical director, a lead nurse and a divisional director of operations.
- At departmental level there was a consultant lead and a matron. The consultant lead had been in post for a number of years. However, the matron had only been in position for a few weeks prior to the inspection.
- There was a co-ordinator on every shift who was responsible for managing the department on a daily basis.
- We found that the new leadership team had only had a minimal amount of time to make any significant improvements to the department and had acknowledged that this would take a longer period which was reflected in the review dates of the service improvement plan.
- We saw that leaders were visible throughout the department and that they interacted well with staff. However, staff told us that this had not always been the case and that the management team had not always been approachable or supportive.
- There was a practice education facilitator within the department who monitored staff appraisals and mandatory training.

Culture within the service

- Staff told us that they did not always feel valued and respected by the trust. We were told that management had not always been visible or approachable prior to the inspection.
- Staff felt under pressure by the increased demand on the service and told us that either a lot of shifts were not covered or were covered by bank and agency staff. This was reflected by a high staff turnover which was at 11.54% for nursing staff and 17.74% for medical staff at the time of the inspection. In addition, sickness rates were 8.96% for nursing staff which was higher than the trust target of 5.84%.
- We were told that incident reports were not always completed as they did not see the point in doing them as there was often no feedback provided or nothing was done about them.
- New staff felt that they were not always supported. For example, supernumerary periods were not always provided for new staff so that they felt confident in undertaking their roles. The management team confirmed that this had been the case as a result of an increased demand on the service.
- Staff also told us that relationships with other departments in the hospital had deteriorated due to the pressures created by the lack of beds and the need to transfer patients out of the department.
- The NHS staff survey for 2015 showed that only 49% of staff would recommend the trust as a place to work. This was below the national average of 55%. However, this was trust-wide and could not be disaggregated specifically for North Manchester General Hospital.

Public and staff engagement

- We did not see any evidence of the department seeking feedback from the public in a way that could have been used to inform service improvement.

Urgent and emergency services

- We were told that regular engagement with nursing staff had not always been facilitated. We were told that there had not been any band 5 meetings for staff to attend. However, the new management team had plans to introduce this on a monthly basis.
- We did not see any information displayed around the department highlighting areas of good performance or areas in need of improvement. As a result staff told us that they were unsure of how performance was currently being measured and what key areas for improvement were.
- Staff received information by emails and via the intranet. The chief executive sent out a Monday message on a weekly basis and other important information could be seen on bulletin boards or were sent out by email.
- In 2014, the 'chief executive's challenge' was introduced and staff were asked to be involved in developing the vision and values of the trust. This challenge received 27,000 ideas from the workforce.
- Staff had also been asked to give their views on reducing staff sickness rates. The development of the trusts "healthy, happy, here" programme was the result of the 44,000 contributions.

Medical care (including older people's care)

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

Information about the service

Medical care (including older people's care) is provided at North Manchester General Hospital (NMGH) from eight inpatient wards, a coronary care unit and an ambulatory care centre called the Manchester treatment centre. The Manchester treatment centre is open seven days a week. There are five bed spaces in this area. Ward J3/J4 is the infectious diseases regional centre for Greater Manchester.

There is an inpatient and outpatient endoscopy unit. The endoscopy unit has four endoscopy suites and runs a planned inpatient and outpatient endoscopy service Monday to Friday. Emergency endoscopy is also available 24 hours a day.

We visited the hospital as part of our announced inspection between 23 February and 3 March 2016. We inspected wards E1, E3, the medical emergency unit, H4, J3, J4, J6, coronary care unit, the endoscopy unit and the Manchester treatment centre. We completed an unannounced visit on 17 March 2016, which also included a visit to ward F4 as well as further checks on E3, MEU and the Manchester treatment centre.

As part of our inspection, we observed care and treatment and looked at 22 sets of patient records. We spoke with 40 staff, including nurses, doctors, consultants, support workers, managers and allied health professionals. We also spoke with nine patients and carers using the services at the time of our inspection. We looked at information provided by the trust and other relevant information we requested.

Summary of findings

Overall we judged the service was inadequate. We found that medical services at North Manchester General Hospital were inadequate in the safe and well-led domains. They required improvement in the effective and responsive domains. Caring was good.

- Incidents were not always investigated in a timely way and staff did not always receive feedback from incidents.
- Learning was not shared through established systems and channels.
- Mortality and morbidity was not discussed at divisional meetings.
- The duty of candour regulation was not widely understood by staff on the wards.
- Problems with the environment on many of the wards and areas we visited meant that infection control best practice could not always be followed.
- Some wards shared sluices and clinic rooms or staff had to move between wards to care for patients. Staff were unaware of plans in place to manage these difficulties if there were outbreaks of infection. Infection control audits did not take place on a regular basis on some wards.
- The Manchester treatment centre was not a suitable environment for patients to stay overnight as there were no facilities for them to wash or to store belongings. Records were not stored securely and record keeping was not in line with best practice

guidance. We noted that essential information was not always documented on the written handover. The most recent audit showed there had been no improvement in record keeping from 2014/15.

- Intentional rounding was not completed in a timely and effective way. The trust protocol for the use of early warning scores was not always used. Deteriorating patients were not always referred for a medical review and repeat early warning scores were not performed to monitor for any further deterioration. Staff on the medical emergency unit (MEU) had not received training to use the continuous cardiac monitoring in place on four beds and there was no monitoring system in place at the nurses station.
- Thickening agent was stored at patient's bed areas without appropriate risk assessments despite a patient safety alert that was issued in 2015.
- Some wards reported that low staff numbers prevented them from being released to undertake training.
- There had been high use of bank and agency workers on some medical wards. Staff told us that this could impact on patient care if the skill mix was reduced, for example patients booked to attend the planned investigation unit had their appointments cancelled
- With regards to medical cover there was a high rate of locum use, particularly on the medical emergency unit where 70% of shifts were filled by locum doctors.
- Hospital performance on the heart failure audit and national diabetes inpatient audit was worse that the England average. We saw that performance on the heart failure audit and some of the indicators for the diabetes audit had reduced over time. The overall risk of readmission was slightly higher than the England average, although length of stay was generally lower.
- Appraisal rates were low for staff on medical wards and in endoscopy. Information provided by the trust showed that none of the areas were meeting the trust target that 90% of staff would have an up to date appraisal. On some wards, the appraisal rate was as low as 23%.
- Staffing shortages or the use of bank and agency staff meant that staff could not always develop the skills and competencies they needed to provide more specialist care and treatment.
- The Mental Capacity Act and deprivation of liberty safeguards (DOLs) were not understood by all staff, although we did see one team following best practice during a best interests meeting. DOLs applications were not always made in a timely way and MCA, DOLs and best interest processes were not documented adequately.
- Bed occupancy rates were high on medical wards and patients could not always access a bed on the most suitable ward.
- Patients waited for longer than necessary for beds and more than half of patients were moved once of more during their admission.
- Patients were moved overnight when necessary although trust policy was that patients should not be moved between 8pm and 8am. Specialist beds on the infectious diseases ward could not be used for their intended purpose because they were filled with medical outliers.
- There was an escalation bed available, but sometimes patients were admitted to the Manchester treatment centre when bed pressures were high. Staff told us the centre was sometimes used to house patients from accident and emergency who were awaiting medical beds.
- The Manchester treatment centre was not a suitable environment for inpatient stays.
- On the day of our visit to the Manchester treatment centre, there was a mixed sex breach due to the lack of availability of surgical beds.
- The planned investigation unit was only available for female patients due to its co-location with an inpatient female ward. Male patients had to travel to other sites for this service.
- Complaints were not investigated and completed in a timely way. Complaints took an average of 21 weeks to resolve and close although some complaints took more than 40 weeks.
- There were governance and risk management structures in place; however these were not always effective in ensuring that safety and quality was being measured and monitored.

Medical care (including older people's care)

- Not all risks were identified and managed appropriately. For example, there were no plans in place to manage wards sharing facilities in the event of an out break of infection.
- The division was not monitoring the use of escalation beds or boarding patients at the Manchester treatment centre and so did not have a sound oversight of bed capacity issues.
- Many leaders at ward level were new in post and their leadership was therefore in its infancy, although staff spoke positively of the changes.
- Staff told us there was a culture of bullying at some levels and historically, there had been bullying on some wards.
- Senior nurses told us they rarely received positive feedback and had been worried that information shared in our focus groups may be passed on to more senior staff. They were concerned about the consequences of being honest with our inspection team. They felt there was a blame culture when things went wrong.

However

- Nursing staffing levels on medical wards had been assessed using a recognised acuity tool. Fill rates were good for qualified and unqualified nursing staff during the day and at night. Verbal nursing handovers were comprehensive
- Medical consultants provided cover seven days a week. Junior and middle grade doctors were available 24 hours a day alongside the hospital at night team. They could access the consultant on call at all times.
- There was a business continuity plan in place and escalation beds available to use when there were bed capacity difficulties. The infectious diseases unit was the regional centre for cases of suspected Ebola and staff had undertaken simulation training to prepare.
- Care and treatment was provided in line with national guidance from NICE and Royal College of Physicians, the Royal College of nursing and locally produced guidelines
- Pain was managed effectively and patients were provided with timely pain relief. Nutrition and hydration assessments were completed and referrals made to relevant team members when this was needed. Staff had been supported to develop extended skills in some areas, for example the care certificate and specific competencies for working on the respiratory ward. Multi-disciplinary working was well established within the hospital, with the mental health trust and with teams from the community. There was access to seven day diagnostics, endoscopy, cardiac pacing and mental health input. Occupational Therapy was provided seven days a week but patients could only access respiratory physiotherapy at the weekend. The Manchester treatment centre was open seven days a week.
- Patients were cared for by staff who were kind, caring and compassionate. Staff respected and upheld patient's privacy and dignity. Friends and family test response rates were high and results were generally positive. Some wards frequently received 100% positive feedback. The trust scored in the top 20% for 25 out of 34 areas on the inpatient cancer experience survey in 2013/14. The trust was performing better than the England average for all four parts of the patient-led assessments of the care environment.
- Communication was sensitive when providing patients with distressing information. Families and loved ones were involved in decisions about care and treatment. Open visiting allowed patients' loved ones to be more informed about plans for care and to provide them with additional emotional support. Patients told us they were given enough information about their care and time to ask questions. Specialist nurses were available for additional information and emotional support. Chaplaincy support was provided Monday to Friday and was available urgently out of hours and there was a multi-faith prayer room on site.
- There was a good awareness and understanding of patients individual needs. A new system was in place to identify patients with specific needs such as dementia or at risk of falling. There was a dementia nurse consultant and a trust wide dementia strategy and some wards had begun to make changes to the environment to make them more dementia friendly. One to one care was available when patients needed this additional support. The learning disability liaison nurse was notified when a patient was admitted and

Medical care (including older people's care)

wards used a traffic light passport system to help them understand the patient's needs and preferences. Complaints were discussed at governance meetings and lessons learnt shared.

- There were governance and risk management structures in place; however these were not always effective in ensuring that safety and quality was being measured and monitored. The division was not monitoring the use of escalation beds or boarding patients at the Manchester treatment centre and so did not have a sound oversight of bed capacity issues.
- Many leaders at ward level were new in post and their leadership was therefore in its infancy, although staff spoke positively of the changes. Staff told us there was a culture of bullying at some levels and historically, there had been bullying on some wards. Senior nurses told us they rarely received positive feedback and had been worried that information shared in our focus groups may be passed on to more senior staff. They were concerned about the consequences of being honest with our inspection team. They felt there was a blame culture when things went wrong.
- Staff spoke positively about the chief nurse. She visited the ward regularly and staff felt she was approachable. The divisional manager was visible on the wards and seen daily. There were good relationships with the medical team. There was public and staff engagement in quality monitoring and development of the service. Staff awards were held annually and the Ebola task and finish group had recently won the patient safety award.
- The infectious diseases team were involved in a range of research projects and had demonstrated innovation in the delivery of their services.

Are medical care services safe?

Inadequate

We rated the safe domain as inadequate because;

- Incidents were not always investigated in a timely way and staff did not always received feedback from incidents.
- Learning was not shared through established systems and channels.
- Mortality and morbidity was not discussed at divisional meetings.
- The duty of candour regulation was not widely understood by staff on the wards.
- Problems with the environment on many of the wards and areas we visited meant that infection control best practice could not always be followed. Some wards shared sluices and clinic rooms or staff had to move between wards to care for patients. Staff were unaware of plans in place to manage these difficulties if there were outbreaks of infection. Infection control audits did not take place on a regular basis on some wards.
- The Manchester treatment centre was not a suitable environment for patients to stay overnight as there were no facilities for them to wash or to store belongings.
- Records were not stored securely and record keeping was not in line with best practice guidance. The most recent audit showed there had been no improvement in record keeping from 2014/15. Intentional rounding was not completed in a timely and effective way.
- The trust protocol for the use of early warning scores was not always used. Deteriorating patients were not always referred for a medical review and repeat early warning scores were not performed to monitor for any further deterioration. Staff on the medical emergency unit (MEU) had not received training to use the continuous cardiac monitoring in place on four beds and there was no monitoring system in place at the nurses station. Thickening agent was stored at patient's bed areas without appropriate risk assessments despite a patient safety alert that was issued in 2015.
- There had been high use of bank and agency workers on some medical wards. Staff told us that this could impact on patient care if the skill mix was reduced, for example patients booked to attend the planned investigation unit had their appointments cancelled.

- Essential patient information was not always documented on the written nursing handover for example, do not attempt resuscitation.
- There was a high rate of locum use, particularly on the medical emergency unit where 70% of shifts were filled by locum doctors.

However,

- Nursing staffing levels on medical wards had been assessed using a recognised acuity tool. Fill rates were good for qualified and unqualified nursing staff during the day and at night;
- Medical consultants provided cover seven days a week. Junior and middle grade doctors were available 24 hours a day alongside the hospital at night team. They could access the consultant on call at all times.
- There was a business continuity plan in place and escalation beds available to use when there were bed capacity difficulties. The infectious diseases unit was the regional centre for cases of suspected Ebola and staff had undertaken simulation training to prepare.

Incidents

- Staff told us they were encouraged to report incidents using an online incident reporting system. We observed staff reporting incidents during our inspection. Medical services had reported 1115 incidents reported between December 2014 and November 2015. The majority of these incidents were no harm or low harm indicating a good reporting culture.
- However, incidents were not always investigated in a timely way. Hospital acquired pressure ulcers on the medical emergency unit (MEU) and H4 from more than two weeks earlier had not been investigated. This meant that lessons were not learnt or shared quickly.
- Staff told us they did not always receive feedback from incidents they had reported. Senior nursing staff told us that staff only receive feedback from incidents unless it was a serious incident that was investigated. Any lessons learnt were shared 'ad-hoc'. Senior medical staff told us that learning from incidents was shared at the weekly urgent care meeting. We saw that incidents was a standing agenda item on the divisional quality and performance meeting, but did not see evidence that any learning from incidents was shared at this level in September, October and November 2014.
- A trust wide duty of candour policy was in place with an accompanying leaflet to improve staff understanding. The duty of candour regulation is in place to ensure trusts are open and honest with people who use services and inform them and apologise when things go wrong with their care and treatment. Senior managers received specific training in the duty of candour, root cause analysis and being open. However, the duty of candour was not widely understood by staff on the wards although there was a prompt to consider the duty on the incident reporting system. Some staff including doctors had not heard of this duty.
- Doctors shared learning from incidents at 'grand rounds'. Monthly lessons learnt bulletins were issued to be shared at ward meetings. Senior staff told us there were plans to audit how learning from incidents was implemented in practice.
- Senior leaders told us that mortality and morbidity was discussed at the monthly divisional quality and performance meeting although when we reviewed minutes from September, October and November 2015 we did not see evidence that this had been discussed. In infectious diseases, we saw that morbidity and mortality was discussed and any identified learning was shared.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Details of thermometer results were displayed on the wards we visited. In medical services across the trust, there had been a total of 34 catheter associated urinary tract infections (CAUTI's), 59 new pressure ulcers and 89 falls that resulted in harm.
- The service was monitoring incidents of pressure ulcers and falls through their performance dashboard each month and these were reported to the trust quality and performance committee and the board. In September 2015 information showed that the trend for the number of new harms was decreasing except for CAUTI's.
- Monthly nursing metrics checks were completed and reported. This included monitoring of performance in relation to pressure ulcers, infection prevention, continence, tissue viability and nutrition. Ward managers received feedback on their performance and were expected to action any areas that fell below standard. Overall scores for participating wards in the trust between October 2015 and January 2016 showed between 91% and 95% compliance.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- Medical services were visibly clean and tidy. We observed staff using personal protective equipment (PPE) and washing their hands appropriately. Patients told us they thought the environment was clean.
- A green 'I am clean' labelling system was in use on commodes on some wards. On MEU we were told that 'I am clean' stickers were no longer used as they were being used inappropriately. This meant that staff would be unaware if a commode was clean and ready for use or required cleaning to prevent the spread of infection.
- Up to date infection prevention training had been completed by 84% of staff within medical services. The trust target was that 90% of staff would be up to date with this training.
- Handwashing, catheter and cannula audits were carried out by infection prevention and control link nurses to ensure compliance with National Institute of Health and Care Excellence (NICE) guidance to reduce the risk of infection. The most recent audit we saw from October 2015 showed 94% compliance with hand hygiene and 95% compliance with PPE on wards J6, J3 and H4. We did not see evidence that these audits were regularly carried out on other medical wards , although they had been carried out on some wards in August and September. For example audits in September 2015 showed 100% compliance with hand hygiene on medical wards E1, E3, H4, J3 and J6. The use of PPE was 98.2% compliant.
- The environment posed an issue on a number of the wards we visited. Wards MEU and H4 shared a dirty utility and clinic room. Ward J5 had its dirty utility located on J6 and the Manchester treatment centre (MTC) had no clinic or dirty utility. If the sluice was required or linen needed disposing, staff from the MTC had to walk through children's and adults A and E departments to access the dirty utility. This presented a risk to infection prevention and control. There was no risk assessment completed to address this issue or minimise any potential risks. There were no plans in place to manage the issues on the medical wards if there was an outbreak of norovirus, MRSA, C-difficile or carbapenemase producing enterobacteriaceae (CPE). We noted that there was no mechanism to flag patients colonised with CPE on the trust IT system, and that there had been two incidents reported relating to the inability to flag CPE.
- MEU had a bay of patients located on H4. The co-location of patients meant that nursing and medical staff were required to move between wards to care for these patients, providing further risk in the case of an outbreak of infection. There were no hand washing facilities when walking between these two wards. There were no toilet facilities in this bay on H4. This meant that patients shared toilet and washing facilities with patients on H4. Staff had no awareness of plans to manage this if there was an outbreak of infection on either ward.
- There were few side rooms available on medical wards which meant that it was not always possible to isolate patients as required, although ward J6 was a ward of side rooms. Wards E1, E3 and F4 were Nightingale style wards which limited the ability to isolate or cohort groups of patients with infections to prevent the spread of infection. In September 2015 there was an incident reported where a patient required a side room due to clostridium difficile infection and there were none available and therefore the patient could not be isolated.
- There had been one clostridium difficile and one MRSA bacteraemia infection between November 2015 and January 2016 within medical services at NMGH.

Environment and equipment

- Emergency resuscitation equipment was checked daily, although records on the trolley in bay two of MEU were only partially completed on two of the days we checked.
- Patients who had been identified as at risk of developing pressure ulcers were provided with appropriate mattresses and cushions as necessary.
- Data provided by the trust showed that some high risk equipment had not been maintained in line with the planned preventative maintenance schedule. This included 10 syringe pumps that required maintenance checks in May 2015 or earlier. The trust reported that some of this equipment could not be located and that the inventory list was currently being audited and these items would be moved to the 'missing list'. We checked two pumps and saw that these had been checked and maintained appropriately.
- On J6, staff told us that the environment posed a challenge if patients were at risk of falls as many of the side rooms were unobservable. There had been two falls in January and four falls in December.

- There was no lock on the dirty utility room on F4. Haztabs and chlor-clean were stored in here unsecured. The ward manager had asked for a lock to be fitted on this door.
- The division had identified that there were issues with the environment of medical wards at NMGH particularly the Nightingale type wards in relation to mixed sex breaches, patient flow and infection control. There were interim plans in development to relocate some medical services but no agreed plans to address the issue of Nightingale configured wards.

Medicines

- Medicines were stored securely and appropriately. Nursing staff carried keys to access controlled and recorded drugs at all times. Fridges were locked and temperatures were checked and recorded daily. Room temperatures were also checked. We saw that on F4 the maximum fridge temperature was out of range on 4 consecutive days and that no action had been taken to deal with this. This meant that medications could have been stored at the incorrect temperature. We informed the ward manager who reset the thermometer in order to recheck.
- There was a trust wide antibiotic policy for adults in place. The most recent audit in July 2015 showed that 98.6% of antibiotics prescribed at NMGH were compliant with this policy. Staff told us the policy was clear and easy to follow.
- Medication was prescribed using an electronic prescribing system on medical wards although paper based records were used for intravenous (IV) fluids, warfarin and insulin if the doses were variable. We saw evidence in records that written prescription charts were used in A and E. This posed a potential risk for delay or duplication in the provision of medication on admission to MEU. There had been 85 incidents reported about medication between November 2014 and December 2015. We saw that there was only one incident that related to repeat medications being given due to the combination of written and electronic prescribing. This related to a double dose of anti-retroviral treatment and was escalated correctly to the doctor in charge. This was recognised on the divisional risk register and there were plans in place to convert all prescribing to the electronic prescription system.
- Forty four per cent of staff had completed medicines management training. The trust target was 30%.

Records

- Medical records were paper based, although medication was prescribed electronically. Records were not always stored safely and securely. On MEU, two of the notes trollies did not lock and nursing documentation was stored in unsecured pigeon holes at the side of the nurse's station. On F4, notes were stored in unlocked trollies at the side of the nurse's station. Notes were also stored in the ward clerk office on F4 which did not have a lock on the door. This meant that there was a risk that patient confidential information could be viewed by unauthorised people. Ward managers told us they were aware of the risks to information security and had requested locks and lockable notes trollies.
- An audit of record keeping had been carried out with low standard of results. Across the trust, none of the 12 standards were compliant with the requirements set down. There had been no improvement in compliance levels from the previous audit in 2014/15. Standards where record keeping fell particularly low were the documentation of minimum patient identifiers on each page, correct time documentation of retrospective entries and deletions scored out with a single line.
- Records we checked reflected these results. In one record there were nine pages that did not contain minimum patient identifiers. This record also contained blood results for the wrong patient. We informed the nurse in charge of this error and requested that an incident was logged and an investigation completed to ensure patient care had not been affected by this result. We saw that there were loose pages in five out of 22 records. On F4, medical notes were loose and stored in plastic wallets when patient medical records did not arrive on the ward. There was no facility to hold these notes together in a secure temporary file. One set of notes stored in this way contained five pages with no patient identifiable information. This meant there was a risk that patient information could be misplaced or lost.
- There was an action plan in place to improve standards in record keeping. For example ensuring that ward clerks inserted blank history sheets with patient identification visible on every side in patient records and ensuring all junior doctors attend the mandatory record keeping training. Data provided by the trust showed that

at the time of the inspection 94% of doctors at the hospital had completed their information governance training. This training included how to meet standards required to handle patient information.

- Risk assessments were completed in line with national guidelines and stored in nursing documentation. These included nutritional, pressure care, falls risk and bed rail assessments.

Safeguarding

- There were safeguarding policies and procedures in place. Staff were aware of their responsibilities in relation to safeguarding children and adults. There was a trust wide safeguarding lead and support could be gained during working hours from the safeguarding team. There was a trust wide "what to do out of hours" guide for safeguarding on the intranet.
- Safeguarding adults level two and children level two training had been completed by 93% of staff.

Mandatory training

- Overall compliance with mandatory training within medical services was 85% against the trust target of 90%. Mandatory training was a mixture of online and face to face learning and included topics such as moving and handling, equality and human rights, information governance and fire safety.

Assessing and responding to patient risk

- An early warning score (EWS) system was in place to help in assessing and responding to patient risk. Trust wide data showed that early warning scores were not always taken as frequently as required, acted upon or rechecked as necessary when patients were showing signs of deterioration. Between June and November 2015, 83% of patients had their EWS recorded as frequently as required. During the same time period, only 78% of patients with an EWS of 3 or more were referred for a medical review. In November this fell to 65%. Only 56% of these patients had repeat observations taken 30 minutes later to monitor for any further deterioration.
- A range of risk assessments were carried out by nursing staff including falls assessments and the PURPOSE-T (a risk assessment for pressure ulcers). Patients identified as being at risk had appropriate care plans in place. These risk assessments were completed appropriately and reviewed regularly.
- Intentional rounding was not always completed on time or in an effective way. We saw that records did not always set time periods for intentional rounding. For example, on E3 five patients out of eight we checked had not received up to date intentional rounding. Three of these patients did not have access to their nurse call buzzers and three records did not state the required frequency of rounding. On MEU, two patients out of nine we checked did not have an up to date record of intentional rounding. Five of these patients did not have access to their nurse call buzzers even though intentional rounding had been completed less than ten minutes earlier. Documentation of the frequency of rounding was better on E1. All five patients we checked had intentional rounding records completed correctly although two patients had not received rounding in the timeframes set out.
- When we returned to E3 on the next day of our inspection, we saw that out of eight patients we checked, seven had complete intentional rounding records, with time frames clearly documented. One patient had received rounding one hour late and one patient did not have access to their nurse call buzzer.
- When we returned on our unannounced visit, we saw that the seven patients we checked on E3 and six patients on H3 had received timely intentional rounding and records were complete. Two patients on E3 did not have access to their buzzers.
- On MEU, there were four beds with continuous cardiac monitoring equipment in place. There was no telemetry monitoring for these beds at the nurses station and we were told that nursing staff had received no additional training in the use and interpretation of these monitors. This posed a risk to patient safety because nursing staff may not recognise when a patient was deteriorating or may be busy with other patients and unable to monitor these patients as required. On CCU, telemetry was available at the nurse's station and nursing staff had received appropriate training.
- On MEU, we saw two patients who needed fluids modifying with the use of thickening powder. Tubs were placed on bedside tables. There was no clear process in place to assess if it was safe to leave these tubs at the bedside, as advised in the patient safety alert issued in 2015. This was raised with the ward matron who advised that it was unsafe for one of these patients to have thickener within reach at the bedside.

- On E3, there were three patients who required thickening powder in drinks. These patients had been assessed and where it was deemed unsafe to have access to the thickening agent, the thickener was left on the drinks trolley. One patient had direct access to thickener at the bedside as the assessment showed this was safe.
- Where nasogastric (NG) tubes were in use, nursing staff checked the position of the tube by measuring pH acidity from aspirates. This was recorded on an NG aspiration monitoring chart. If it was not possible to obtain an aspirate, a check x-ray was arranged and the position checked by medical staff.
- Medical staff told us there was an e-learning package in use to train doctors to check the position of NG tubes on x-rays. We saw evidence that documentation was structured and clearly stated how the decision that the tube was safe to use was reached.
- On E3, staff told us that they used a method of bay tagging to ensure that a member of staff was always available to observe patients who were high risk of falls or were confused and needed additional support.
- There was clear criteria to determine which patients could be treated at the MTC. The criteria excluded high risk patients who could not be safely managed in this area.
- The waiting area for MTC was not observable by staff in the centre and there was not always an outpatient receptionist in the waiting area. Staff told us that patients received an initial assessment on arrival and if they were too unwell to wait in this area, they would be redirected to accident and emergency.

Nursing staffing

- The Safer Care Nursing Tool had been used to calculate nursing staffing on medic al wards. This was reviewed six monthly, most recently having been reviewed in November 2015. There was a safe staffing escalation process in place which included details of actions to be taken by staff at all levels to ensure safe staffing levels. Wards we visited displayed planned and actual staffing levels for each shift that day. Ward managers were expected to provide details of staffing daily on each shift. This information was gathered by the matrons who looked at overall staffing on medical wards and moved staff to cover short falls if this was required.
- The trust collected data to compare the planned nursing coverage to the actual nursing coverage for each ward. Average fill rates during the day for all medical wards between August and November 2015 was over 101% for registered nurses (RNs) and 97% for unqualified support workers. At night RN fill rates averaged at 112% and 98% for unqualified staff. On CCU, the average fill rate was lower for RNs during the day at 90% however; this remained above the trust target and national benchmark of 80%.
- There had been high levels of bank and agency nursing staff to ensure safe staffing levels on medical wards. Over 12% of shifts had been filled by bank or agency nurses between October 2014 and March 2015, Agency use had been particularly high on E1 and E3, averaging at 20% meaning that one in five shifts was filled by a non-permanent member of staff. There were low rates of agency usage in the endoscopy department (less than 2%). There was a local induction process in place for bank and agency staff.
- The nursing vacancy rate was 10.75%, which was the equivalent of 25 full time RNs. The majority of the vacancies were for band 5 nurses. There were ongoing recruitment programmes to address this shortfall including overseas recruitment.
- Staff on H4 told us that the acuity and dependency of patients on this ward was high. The ward manager had expected to receive increased staffing following the acuity review in November. This ward frequently had patients with tracheostomies, chest drains and patients on respiratory supportive equipment such as NIPPI and BIPAP. Staff told us that staff shortages meant that essential nursing tasks could not be undertaken in a timely way. For example, intravenous (IV) medications or fluids were given late, dressings were not completed and that there had been an increase in the number of hospital acquired pressure ulcers due to late or incomplete pressure area care. Between October 2015 and January 2016 there had been seven hospital acquired pressure ulcers on this ward. The ward manager had been given permission to have an additional support worker on the ward in addition to the planned support workers.
- Hospital at night had not been fully implemented, but there was one band 8a night nurse clinician and one band 7 night nurse manager to support overnight medical cover.

Medical care (including older people's care)

- The MTC was staffed by advance nurse practitioners, supported by health care support workers. On the day of our inspection there were two patients who had undergone CT guided lung biopsies who were receiving post-operative monitoring. There had been no increase in nursing staff numbers to account for this although staff told us they felt that nurse staffing levels were safe at this time.
- On F4, day case patients attending the planned investigation unit were cancelled if staffing levels for the ward were low. This also happened if the skill mix on shift was not adequate to meet the needs of these patients. For example, this happened if there were bank nursing staff on shift with an inexperienced band 5 nurse. This system maintained safe staffing levels on the ward but may result in poor patient experience for patients planned to attend as days cases.
- Nursing handovers took place at each change of shift. We observed two handovers and saw that the verbal handover was thorough and covered patients' needs and plans for care and treatment. However, during one handover we noted that important information such as resuscitation orders was not always documented on the written handover although it was handed over verbally. This could pose a risk that essential information is not shared and could result in unsafe or inappropriate treatment.

Medical staffing

- Consultants were on site Monday to Friday from 8am to 9pm and for six hours on Saturdays and Sundays. Outside of these times, consultant cover was provided on call. There were daily consultant ward rounds, covering both accident and emergency and MEU. This included the handover from the night staff to day staff.
- Junior and middle grade/registrar doctors were on site 24 hours a day, seven days a week. There were no acute medicine registrars in training employed at the time of our inspection. The medical vacancy rate in December 2015 was 4.82%. There were 3.5 WTE consultant vacancies.
- There were high levels of locum use on MEU in particular for junior, middle grade and consultant cover. 70 percent of medical shifts had been filled by a locum doctor between October 2014 and March 2015. Locum usage for general medicine was 51% and care of the elderly was 39%. We were told that these were most often regular locum staff who knew the ward and the processes. Locum doctors told us that they received a full induction to the trust and also completed a local induction. Locum use was low in infectious diseases (7.3%), cardiology (0%), respiratory medicine (5.7%) and endocrinology (1.2%).
- One junior doctor told us that shifts and staffing on MEU did not always meet the needs of patients. For example, there were always more admissions to be clerked during the afternoon but these admissions were often left waiting for the night team to clerk them. This meant that patients could wait for long periods to be seen by a medical doctor.
- We were told that written handovers were provided for patients being admitted to MEU from A and E, but that this information was not always sufficient to provide an effective handover. We saw evidence of written handovers from MEU to other medical wards. These contained comprehensive information regarding patient's medical history, reason for admission, diagnosis, treatment and recommendations.
- A doctor was based on the Manchester treatment centre and worked in conjunction with the ANPs.

Major incident awareness and training

- There was a trust wide business continuity plan in place to ensure services could continue to run in the event of staff shortages, equipment failure or a major incident.
- There was an escalation bed on H4. For patients to be admitted to this bed there needed to be a de-escalation plan in place for the bed to be free within 12 hours.
- The infectious diseases unit had a plan for suspected or confirmed cases of Ebola and staff had completed comprehensive simulated training. The unit was the designated regional centre for cases of suspected Ebola. The infection control team had developed a risk assessment and training competencies that had been shared as best practice with Public Health England and other trusts across the country.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

Medical care (including older people's care)

- Hospital performance on the heart failure audit and national diabetes inpatient audit was worse than the England average. We saw that performance on the heart failure audit and some of the indicators for the diabetes audit had reduced rather than improved over time.
- Appraisal rates were low for staff on medical wards and in endoscopy. Information provided by the trust showed that none of the areas were meeting the trust target that 90% of staff would have an up to date appraisal. On some wards, the appraisal rate was as low as 23%. Staffing shortages or the use of bank and agency staff meant that staff could not always develop the skills and competencies they needed to provide more specialist care and treatment.
- The Mental Capacity Act and deprivation of liberty safeguards (DOLs) were not understood by all staff, although we did see one team following best practice during a best interests meeting. DOLs applications were not always made in a timely way and MCA, DOLs and best interest processes were not documented adequately.

However,

- Care and treatment was provided in line with national guidance from NICE and Royal College of Physicians, the Royal College of nursing and locally produced guidelines.
- The overall risk of readmission was slightly higher than the England average, although length of stay was generally lower.
- Pain was managed effectively and patients were provided with timely pain relief. Nutrition and hydration assessments were completed and referrals made to relevant team members when this was needed.
- Staff had been supported to develop extended skills in some areas, for example the care certificate and specific competencies for working on the respiratory ward.
- Multi-disciplinary working was well established within the hospital, with the mental health trust and with teams from the community.
- There was access to seven day diagnostics, endoscopy, cardiac pacing and mental health input. Occupational Therapy was provided seven days a week but patients could only access respiratory physiotherapy at the weekend. The Manchester treatment centre was open seven days a week.

Evidence-based care and treatment

- Care and treatment was delivered in line with national guidance from NICE, the Royal College of Physicians (RCP) and Royal College of Nurses (RCN) along with locally produced guidelines. There were local pathways in place to support decision making in line with best practice guidance. For example, there were pathways for exacerbation of chronic obstructive pulmonary disease, community acquired pneumonia and an alcohol withdrawal pathway. Guidelines were widely available on the intranet. In endoscopy, procedures were carried out in line with professional guidance produced by NICE and the British Society of Gastroenterologists.
- The Surviving Sepsis Campaign guidelines were followed in the trusts sepsis management guidelines, which included implementation of the sepsis six care bundle along with guidelines for ongoing management.
- There were ambulatory care pathways in place at the MTC for conditions such as deep vein thrombosis, cellulitis and pulmonary embolism.
- Patients received an assessment of their risk of a venous thromboembolism (blood clot) on admission and were given treatment in line with NICE quality statement (QS) 66.
- Medical services participated in all audits they were eligible to complete. In addition to this there was a trust wide audit programme covering compliance with NICE quality standards and guidance. Local audits were carried out in the infectious diseases team. These included TB screening for HIV positive patients, hepatitis and immunisation in HIV. The alcohol liaison team audited the use of vitamin prophylaxis and had developed actions to improve education of staff in this area. The respiratory team had audited practice against standards set out by NICE and the British Thoracic Society.

Pain relief

- There was a quick reference flowchart to guide decisions about pain assessments and pain relief. There were guidelines on the intranet for the management of acute pain and a care plan for pain.
- During intentional rounding, patients were asked if they required pain relief. Patients who required pain relief were prescribed appropriate medication.
- There was a new pain assessment in use that had been specifically designed for patients with dementia. This assessment was an observational tool that also allowed the patient's family to be involved.

- Sedation was used in endoscopy in line with best practice.

Nutrition and hydration

- A coloured tray system was in place to highlight patients who needed assistance with eating and drinking. Patients were offered assistance when needed. Water jugs and cups were available at patients' bedsides.
- Some patients received an assessment of their nutrition and hydration needs on admission but this was not always completed in full. Nurses completed the malnutrition universal screening tool (MUST) and made referrals to dieticians when required. Speech and language therapists (SLTs) prioritised patients who needed a swallowing assessment so that the multi-disciplinary team (MDT) could decide the best way to ensure patients received adequate nutrition and hydration.
- Meal time audits were completed in the hospital conjunction with catering staff, SLTs and dieticians. These audits looked at a number of factors including the quality of food, presentation and nutrition.
- Patients were provided with drinks and snacks following procedures in the endoscopy unit.
- Food standards were reported as good and meals served were hot. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack for them.
- One patient's relative told us that there was no provision for food or drink whilst waiting to be seen at MTC, despite a five hour wait.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/14 showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (NSTEMI-a type of heart attack that does not benefit from immediate percutaneous coronary intervention) seen by a cardiologist prior to discharge was better than the national average at 97.5%. Only 29.5% of patients with an NSTEMI were admitted to a cardiology ward. This was worse than the England average of 55.6%. The hospital scored better than the England average for the number of NSTEMI patients who had or were referred for angiography.
- The 2013/14 heart failure audit showed the hospital performed worse than average for all four of the clinical (in hospital) indicators and better than the England average in four of the seven clinical (discharge) indicators. This was a reduction in performance from the audit in 2012/13 where the hospital had performed better in six of the clinical (discharge) indicators. There had been some improvements noted however, for example in 2012/13 only 28% of patients had input from a consultant cardiologist in comparison to the England average of 57%. In the most recent audit this had improved to 46% in comparison to the average of 60%.
- In the 2013 national diabetes inpatient audit (NaDIA), the hospital was worse than the England average in 10 indicators and better than the average in seven indicators. Most of the negative results related to meal provision and staff knowledge and support. The numbers of patients visited by a specialist diabetes team was 25.7% compared to the England average of 34.5%. This number had decreased from the previous audit result of 28.1% carried out in 2012. However, seven of the indicators had seen improvements since the audit in 2012.
- The overall average length of stay for elective admissions was 1.8 days and non-elective admission was 4.8 days which was was much lower than the England average of 3.8 days and 6.8 days. Non-elective cardiology was the only speciality with a longer length of stay at 2.5 days longer than average.
- The overall relative risk of readmission for elective and non-elective care was slightly above (worse than) the England average, although for elective gastroenterology the risk of readmission was much higher. Divisional managers told us there were problems with data collection that may have skewed these results.
- On MEU, consultant sign off was required before patients were listed for a bed on a medical ward. This ensured that patients were only admitted to a ward when they required further care and treatment.
- The endoscopy unit was accredited by the Joint Advisory Group on GI Endoscopy (JAG). JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards. The unit had been visited in May 2015 and we saw that the recommendations from this visit had been completed.

Competent staff

- Appraisal rates were low on most medical wards and in endoscopy. Between April 2015 and November 2015 only 37.5% of registered nursing staff on F4 and 23% on J6 had received an appraisal. The rate was 53% of nursing staff in endoscopy. The rates were higher on E3, H4 and CCU at over 70% but still did not meet the trust target of 90%. We saw that appraisal rates had also been low in 2014/15. Appraisal rates for administrative and clerical staff were generally higher.
- Across the trust, 12% of medical staff had completed their appraisal by August 2015 and 76% were on target to complete their appraisal by the target date of February 2016.
- Nine HCAs in medicine across the trust had completed the care certificate. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants. The trust was involved in the apprenticeship nursing scheme for nursing and administrative staff with the skills for health academy. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required. Unqualified staff were supported to develop their skills. On F4, support workers were being trained to be basic life support assessors and to share skills in using new blood pressure monitoring equipment.
- Competencies had been developed on the respiratory ward, to help nursing staff improve their skills in specialist nursing. Acute physicians had special interests in specific areas, for example toxicology, respiratory medicine and infectious diseases, and undertook additional training in these areas.
- There were plans to support nursing staff with the new system of revalidation and a launch date had been arranged to publicise this. All ward managers were taking part in a leadership development course.
- The trust supported the development of extended skills in some areas. For example, there were advanced nurse practitioners in the MTC and prescribing pharmacists supported the delivery of the infectious disease service.
- SLTs had trained senior nurses to become 'dysphagia trained'. This meant that patients could access a basic swallowing assessment 24 hours a day.
- There was not always enough time to release staff to complete additional training to improve their skills. On H4, supernumerary staff worked in the nursing numbers to allow staff to attend training. On F4, newly qualified band 5 nurses were unable to develop the skills needed to work in the planned investigation unit due to staffing shortages, vacancies and long term sickness.
- Long standing locum doctors told us they were able to access the same training as permanent staff and spoke positively about the opportunities available to develop their knowledge and skills.

Multidisciplinary working

- Multidisciplinary working was well established on medical wards. There was access to physiotherapy, occupational therapy, SLT and dieticians. We saw therapists working with patients on the wards during our inspection and observed team members sharing information about patients care, treatment and plans for discharge. Daily board rounds were held on each medical ward. These were attended by members of the multidisciplinary team (MDT).
- On MEU, a handover was held at midday. This was attended by junior doctors, consultants, a pharmacist, the nurse in charge and the nurse caring in charge of each bay. Navigators or social workers were informed about complex discharges from this meeting.
- We observed a bed management and delayed transfer of care meeting and saw that there was good multi-disciplinary working. This meeting was attended by senior nursing staff, social workers, community therapists and divisional managers.
- There was evidence of partnership working with the local mental health trust to deliver services for those patients with mental health, drug or alcohol issues. The rapid assessment, interface and discharge (RAID) team visited inpatients on medical wards to provide assessment, advice and intervention.

Seven-day services

- There was access to X-ray and CT scanning 24 hours a day, seven days a week. The magnetic resonance imaging scanner (MRI) operated Monday to Sunday 8am to 8pm.
- There were two medical consultants on shift at weekends. Consultants saw patients on MEU who required a senior review and outliers on Saturdays and Sundays. Consultants were on site for at least six hours per day at the weekends and on call cover was provided out of these hours.

- There was access to input from specialist medical teams at weekends such as cardiology. Emergency endoscopy was available 24 hours a day to manage gastrointestinal bleeding. The psychiatric liaison service was available 24 hours a day.
- There was a pacing room on the cardiac care unit (CCU). This was available for emergency use 24 hours a day as well as providing planned care to patients.
- Occupational therapy was provided at weekends. Physiotherapy was provided for patients with respiratory problems at weekends and also to facilitate discharge from medical wards. There was a navigator system in operation seven days a week to speed up discharges from MEU for patients who were medically fit for discharge.
- The Manchester treatment centre was open seven days a week from 8am to 9pm.

Access to information

- Staff had access to the information they needed to provide care and treatment to patients. Records were available on the ward and there were sufficient numbers of computers to allow access to test results and trust policies and procedures.
- There were folders available on the wards to provide additional information to support the delivery of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) training was included in adult safeguarding mandatory training. This had been completed by 93% of staff in medical services. Some staff had been identified to complete level three safeguarding training which included more in depth information about the MCA. Compliance with this level of training was 70%.
- Staff were able to tell us how they assessed mental capacity in line with the MCA. We observed a best interest meeting for a patient on E1. This meeting was attended by relevant professionals, family members and the patient in line with good practice. During this meeting staff demonstrated a good understanding of the MCA and were able to explain the Act to the patient and his family.
- There was an enhanced observation policy in place for patients requiring additional supervision. This contained clear guidelines on risk assessments for this patient group and procedures to follow if a patient required additional observation or one to one care. There were care plans for patients receiving enhanced observation and logs to be completed. We saw that emergency and standard DOLS applications were made for patients receiving one to one care in line with this policy.
- Deprivation of liberty was not fully understood by all staff. One member of staff told us that training on deprivation of liberty safeguards (DOLS) was "skirted over" in the mandatory safeguarding training. We saw evidence that DOLs applications had been made appropriately, but there appeared to be a delay in making applications in a timely way. For example, in one case it had been identified that the patient would need to be deprived of his liberty but it had taken four weeks for the application to be made. In the notes we reviewed, there was inadequate documentation of DOLs, the MCA and best interest processes.
- One patient told us he had not been able to leave the ward to have a cigarette. This gentleman was an amputee and was dependent on a walking aid or wheelchair for his mobility. He had not been provided with any means of mobilising on or off the ward. When we asked whether this was a deprivation of liberty, staff told us that the patient was on the ward due to attempted suicide and it was therefore favourable that he was unable to leave the ward. We asked staff to consider whether this meant he needed to have his capacity assessed in line with the Mental Capacity Act, be subject to the Mental Health Act or alternatively be enabled him to leave the ward.
- Although the bed rail assessment prompted nurses to consider mental capacity, it was not documented on the assessment. Capacity should always be considered when using bed rails as this could be considered a deprivation of liberty.
- Consent was taken from patients attending endoscopy on the day of the procedure. We saw that informed written consent was documented in patient records. An audit of consent was undertaken across the trust. The most recent audit had showed that an incorrect consent form four was being used. Actions were identified and had been completed to deal with this error.

Are medical care services caring?

Medical care (including older people's care)

Good

We rated caring as good because:

- Patients were cared for by staff who were kind, caring and compassionate. Staff respected and upheld patient's privacy and dignity. Friends and family test response rates were high and results were generally positive. Some wards frequently received 100% positive feedback.
- The trust scored in the top 20% for 25 out of 34 areas on the inpatient cancer experience survey in 2013/14. The trust was performing better than the England average for all four parts of the patient-led assessments of the care environment.
- Communication was sensitive when providing patients with distressing information. Families and loved ones were involved in decisions about care and treatment. Open visiting allowed patients' loved ones to be more informed about plans for care and to provide them with additional emotional support.
- Patients told us they were given enough information about their care and time to ask questions. Specialist nurses were available for additional information and emotional support.
- Chaplaincy support was provided Monday to Friday and was available urgently out of hours and there was a multi-faith prayer room on site.

Compassionate care

- Staff treated patients with compassion, kindness, dignity and respect. Patients told us that staff on MEU were hardworking, caring, kind and courteous. One patient described the care he received as "first rate".
- We received very positive feedback about CCU. Friends and family test (FFT) results showed that for 11 out of 12 months between November 2014 and October 2015, 100% of patients would recommend this ward to their friends of family. The response rate for this ward was high at 77% (213 responses). The England average response rate is 33.7%. Many of the medical wards received 100% recommend rates in the FFT although there were some months when these figures fell to as low as 74 or 75% on J3 and E3.
- We saw that staff in endoscopy were caring and compassionate. Ward staff acted with care and compassion during a best interests meeting when providing distressing and information to the patient and his loved ones.
- We witnessed one negative interaction between support workers. The day support worker offered the patient her buzzer and the night support worker responded saying "she's been after that all night".
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts for 25 of the 34 areas. These included 'patient given the choice of different types of treatment, 'always given enough privacy when being examined or treated' and 'nurses did not talk in front of them as if they were not there'. The trust fell in the bottom 20% of trusts for 'all staff asked patient what name they preferred to be called by' and 'family definitely given all information needed to help care at home'

Understanding and involvement of patients and those close to them

- We saw that staff knew the patients they were caring for and their individual needs and preferences.
- Patients told us that doctors were "very thorough" and gave them enough information about their care and treatment. They were given time to ask questions.
- Patients and their families were involved in planning care, treatment and discharge. Staff ensured that patients were supported by their loved ones during best interests meetings. We observed that staff were very supportive towards a concerned relative in endoscopy.
- One relative told us that patients were not always involved in their care and treatment and did not always receive enough information. Relatives were not always informed of ward moves, although the move had happened overnight.
- Patients received written information about their care and treatment from specialist nurses.

Emotional support

- Open visiting was in place to allow carers and family members to offer additional emotional support whilst their loved one was in hospital. Patients and relatives told us they were happy that open visiting was in place as it allowed them to offer additional support and to be more informed about care and treatment.

Medical care (including older people's care)

- In endoscopy, staff at all levels were supportive and offered good levels of emotional support to patients and relatives.
- There was access to acute oncology, palliative care, diabetes and infectious diseases specialist nurses.
- Cardiology specialist nurses for heart failure and cardiac rehabilitation were available and visited patients on CCU and step down medical wards. Nurse led clinics were held. These clinics offered additional emotional support to patients.
- Chaplaincy services were available for patients and relatives Monday to Friday and also access urgently out of hours. There was a multi-faith prayer room at the hospital.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Bed occupancy rates were high on medical wards and patients could not always access a bed on the most suitable ward. Patients waited for longer than necessary for beds and more than half of patients were moved once of more during their admission. Patients were moved overnight when necessary although trust policy was that patients should not be moved between 8pm and 8am.
- Specialist beds on the infectious diseases ward could not be used for their intended purpose because they were filled with medical outliers.
- There was an escalation bed available, but sometimes patients were admitted to the Manchester treatment centre when bed pressures were high. Staff told us the centre was sometimes used to house patients from accident and emergency who were awaiting medical beds.
- The Manchester treatment centres was not a suitable environment for inpatient stays.
- On the day of our visit to the Manchester treatment centre, there was a mixed sex breach due to the lack of availability of surgical beds.
- The planned investigation unit was only available for female patients due to its co-location with an inpatient female ward. Male patients had to travel to other sites for this service.
- Complaints were not investigated and completed in a timely way. Complaints took an average of 21 weeks to resolve and close although some complaints took more than 40 weeks.

However,

- The overall average length of stay was much lower than the England average although non-elective cardiology had with a longer length of stay than average.
- There was a good awareness and understanding of patients individual needs. A new system was in place to identify patients with specific needs such as dementia or at risk of falling. There was a dementia nurse consultant and a trust wide dementia strategy and some wards had begun to make changes to the environment to make them more dementia friendly.
- Open visiting was in place and this had had a positive impact on patient care.
- One to one care was available when patients needed this additional support. The learning disability liaison nurse was notified when a patient was admitted and wards used a traffic light passport system to help them understand the patient's needs and preferences.
- Complaints were discussed at governance meetings and lessons learnt shared.

Service planning and delivery to meet the needs of local people

- The trust was part of the regional healthier together and devolution Manchester programmes of work to improve health services for local people.
- The infectious diseases team had developed a number of innovative services to meet the needs of local people. There was a ward attender clinic for rapid review after discharge, outreach services for patients with co-morbidities, nurse led clinics for blood borne viruses within prison services. The ID team had developed fail safe arrangements for patients who did not attend or were homeless.
- Male patients were unable to access the planned investigation unit (PIU) at NMGH. This was to maintain

the privacy and dignity of female patients because the PIU was co-located on a female medical ward. Male patients had to travel to one of the other hospital sites to undergo planned investigations.

Access and flow

- Bed management meetings were held four times a day to discuss current bed state and predicted bed requirements. At one of these meetings, delayed transfers of care were also discussed. Where patients were awaiting diagnostic testing prior to discharge, there was a system in place to escalate and speed up the discharge process.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Between July and October 2015 72 patients were cared for on wards that did not best suit their needs. This added up to 297 bed days. Medical outliers were cared for by a dedicated consultant and junior doctor team. Daily ward rounds were held for outliers.
- There were a total 1,002 patients moved overnight between November 2014 and October 2015. The majority (871) of these moves were from MEU. Trust policy was that patients should not be moved between 8pm and 8am. Large numbers of patients experience multiple ward moves during their admission. Between November 2014 and October 2015, 45% of patients experienced at least one ward move and 10% of these patients were moved twice or more.
- The average bed occupancy rates across all medical wards was 93.4% between October and December 2015. Some wards had very high bed occupancy rates, for example in October and November J3 had a bed occupancy rate of 98.3% It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- There were issues with patient access and flow. Patients waited on MEU for longer than necessary due to bed shortages. One patient had been waiting for a medical speciality bed for seven days. Staff on J6 told us that there had been some instances where patients had been transferred to other local hospitals for an angiography procedure and when the patient returned, the bed had been given away.
- Staff on CCU told us that there was often a wait to step patients down from this unit to beds on other medical wards. On the day we visited this unit, two out of six patients no longer required the level of care provided on CCU and were awaiting medical beds. This meant that patients needing admitting to CCU may not be able to access the care they need although bed occupancy rates were lower on CCU, at an average of 86.6% between October and December 2015.
- Beds on the ID ward were often filled with outlying medical patients. This meant that patients requiring induced sputum for suspected tuberculosis (TB) waited for up to 12 weeks for this investigation. Specialist negative pressure rooms could not be used for their intended purpose. There had previously been a trolley area that was used to provide specific specialist treatment to patients with HIV but this was now in use as a medical bed.
- There was an escalation bed on H4 however the trust did not collect data about how often this bed was used. Staff told us that the MTC was used when there were bed shortages. The trust were unable to provide details of how many times this had happened or how many patients had needed to stay overnight in the MTC.
- Ward F4 was used as a medical discharge ward. Patients were moved here when they were medically fit for discharge but were not yet ready to be discharged as they had ongoing therapy or social work needs.
- Discharge plans were discussed during nursing handovers. There was a patient flow team available Monday to Friday who supported staff with issues regarding access and flow. Staff told us there were often long delays for packages of care to be arranged. Divisional leads told us that approximately 20% of medical beds across the trust were filled with delayed discharges. This equated to around 100 beds across the three main sites. There was no discharge lounge at NMGH. Delayed discharges was identified as an area of risk in medical services and was on the risk register with actions identified to mitigate the risk.
- The overall average length of stay for elective admissions was 1.8 days and non-elective admission was 4.8 days which was was much lower than the England average of 3.8 days and 6.8 days. Non-elective cardiology was the only speciality with a longer length of stay at 2.5 days longer than average.
- Patients were referred to the MTC by GPs. Patients received investigations and treatment here and were

discharged. If discharge was not appropriate, a referral would be made to MEU for admission to the hospital. Patients typically waited at the centre for two to three hours. Staff at the MTC told us that the centre was not always used appropriately. The centre was sometimes used to hold patients from accident and emergency (A and E) who were awaiting beds on medical wards to ease the flow of patients in A and E and GPs referred patients who clearly needed admitting to hospital. Incidents were logged if patients were sent inappropriately from A and E. In the incidents we reviewed we did not see any that identified this issue.

- On the day of our visit to the treatment centre, there were two male patients who had undergone lung biopsies on the unit. Staff told us that usually these patients were admitted to ward C3 following the procedure for monitoring, but on this day there were no available beds. The centre was therefore being used inappropriately due to a lack of surgical beds. Staff also told us that the treatment centre had been used as a ward area during times of bed pressures.
- Relatives told us that discharge plans were shared with them. Staff identified that discharges would be quicker if there was access to physiotherapy and social work input over the weekend.
- There was access to the navigator team seven days a week on MEU. This team accepted referrals for patients who were medically fit for discharge but were not safe to be discharged home due to mobility difficulties or difficulties caring for themselves at home. The team was able to help to discharge patients quickly for example by arranging emergency respite, referrals to intermediate care or urgent care packages.
- Between November 2014 and October 2015 referral to treatment times (RTT) for all medical specialities including cardiology and gastroenterology were above the England average and the trust target of above 92%. General medicine and geriatric medicine were 100% compliant with the 18 week RRT.
- We were told that the booking system for endoscopy did not always take account of consultant holidays. This meant that the patients who had bowel preparation completed were absorbed into other lists and some patients were cancelled on the day of the procedure. We were told this had happened four times in the previous six months. Nursing staff shortages and bed shortages also limited the full running of the endoscopy unit. On the day of our visit to the endoscopy unit, one patient had his procedure cancelled as there was no bed available. Staff told us that two patients had been cancelled for the same reason the day before.

Meeting people's individual needs

- A new system to identify patients with specific needs was being implemented at the time of our inspection. This included a flower to identify patients with dementia and a leaf to identify those at risk of falls. The symbols had not yet been received on the wards we visited and there were temporary symbols in use.
- The EPR system alerted staff to cognitive impairment, including dementia. The system automatically sent a safeguarding referral if assessments such as the abbreviated mental test indicated cognitive impairment.
- Across the trust 5982 patients with dementia were admitted last year. There were 125 inpatients with dementia at any one time. There was a dementia nurse consultant in post for the trust. Assessments of dementia were completed in line with national guidelines. The 'find, assess, investigate, refer, inform' criteria were used alongside assessments such as the abbreviated mental test and the confusional assessment method. The wards we visited used the "This is me" document
- There was a trust wide dementia strategy. Monthly audits were completed to ensure patients were being screened for dementia. An annual survey for carers of people living with dementia was undertaken. The trust was planning to participate in the 2016 dementia audit. Staff were able to tell us how they approached care for patients living with dementia. One to one support ('patient watch') was provided where this was felt necessary.
- Senior nurses had recognised that the environment on MEU was not suitable for patients living with dementia and were working with the dementia nurse consultant to look at ways to make the environment more dementia friendly. Some wards had access to memory boxes that contained reminiscence materials. There were also new "reminiscence" electronic tablets in use on some wards. These tablets allowed staff to set up individual activities such as bingo and music and also to

information about life history and personal preferences. We saw this being used with one patient and that this had a positive impact on her care. Her relatives told us that she "loves using it".

- There was a flagging system in place for patients with a learning disability. Information was shared between local community and mental health trusts. An email automatically generated and sent to the LD liaison nurse. Across the trust last year, 783 patients with a learning disability were admitted. A traffic light passport was used. The care provided to patients with as learning disability was audited in line with the trust wide Learning Disability Quality Assurance Framework. Staff told us about the traffic light passport system. They also told us that carers were encouraged to stay where possible, including paid carers who were known and familiar to the patient.
- Translation services were available via a bank of 107 interpreters. The most requested languages were Urdu, Punjabi, Bangla and Polish. Staff told us that they had rapid access to face to face interpreters.
- There was an open visiting policy in place. Patients and their relatives spoke positively about this. Staff also reported that there had been a positive impact on patient care.
- At the MTC, we saw that there was a mixed sex breach on the day of our inspection. Two male patients who had undergone operative procedures were in beds, wearing gowns and with only one mixed sex toilet. This environment did not preserve their privacy and dignity.
- MTC was an unsuitable area for patients to stay overnight. There were no washing facilities, no suitable storage facilities for personal belongings and only one toilet. We were told that patients had stayed as inpatients here for up to three days. When we returned on our unannounced visit, the centre had been used for three inpatients due to bed pressures.
- Diabetes specialist nurses were unable to see all referrals made to them. They prioritised referrals based on a 'traffic light' system and frequently only saw those who were a high priority.
- Ward F4 had a planned investigation unit attached to it. This service provided treatment and investigations for day case patients such as IV infusions and blood transfusions. It had also been used for chemotherapy treatment. Only female patients were accepted here to prevent mixed sex breaches. This meant that male patients had to travel to other sites for these treatments. This decision had been made to prevent mixed sex breaches rather than clinical need or the needs of the local population.
- There was a pharmacy satellite room on F4. This room was a storage room placed inappropriately at the end of a Nightingale type female ward. Senior staff told us that pharmacists used this room to store mobile laptop stations and some take out medication. This meant that patient's privacy and dignity could be placed at risk.
- Patients told us that they sometimes waited for long periods before being attended to by nurses.

Learning from complaints and concerns

- There were 58 complaints about medical services between 1 December 2014 and 31 December 2015. There were no complaints about endoscopy during this time. Frequently, complaints took longer than acceptable to investigate and close. On average it took 106 days (more than 15 weeks) to close a complaint about medical services. Some complaints took up to 285 days (more than 40 weeks) to resolve and close.
- A quarterly learning from experience report was sent to the trust board. This included details of complaints and contacts through the patient advice and liaison service (PALS) identifying themes and trends.
- Complaints were discussed at governance meetings which also outlined key lessons learnt to be shared with staff. Staff were able to give examples of complaints and how lessons learnt from these had been shared and practice changed.
- Patients were invited to discuss their complaint and were involved in determining the lessons learnt from complaints.

Are medical care services well-led?

Inadequate

We rated well-led as inadequate because:

- Governance and risk management structures were in place; however these were not effective in ensuring that safety and quality was being measured and monitored.
- Not all risks were identified and managed appropriately. For example, there were no plans in place to manage wards sharing facilities in the event of an out break of infection.

Medical care (including older people's care)

- The division was not monitoring the use of escalation beds or boarding patients at the Manchester treatment centre and so did not have a sound oversight of bed capacity issues.
- Many leaders at ward level were new in post and their leadership was therefore in its infancy, although staff spoke positively of the changes.
- Senior nurses told us they rarely received positive feedback and had been worried that information shared in our focus groups may be passed on to more senior staff.
- Staff told us there was a culture of bullying at some levels and historically, there had been bullying on some wards. They were concerned about the consequences of being honest with our inspection team. They felt there was a blame culture when things went wrong.

However,

- Staff spoke positively about the chief nurse. She visited the wards regularly and staff felt she was approachable. The divisional manager was visible on the wards and seen daily.
- There were good relationships with the medical team. There was public and staff engagement in quality monitoring and development of the service.
- Staff awards were held annually and the Ebola task and finish group had recently won the patient safety award.
- The infectious diseases team were involved in a range of research projects and had demonstrated innovation in the delivery of their services.

Vision and strategy for this service

- The trust's vision was to be a leading provider of joined up healthcare that would support every person who needed services, whether in be in or out of hospital, to achieve their fullest health potential. The values were to be quality driven, responsible and compassionate. The values were clearly displayed throughout the hospital and staff told us they were aware of the vison and values.
- The division of medicine did not have a specific divisional strategy but was included in the trust's urgent care implementation plan and trust transformation strategy.
- NHS staff survey results for 2015 showed that 76% of staff in medical services said they had clear planned objectives; however this did not reflect the current level of appraisal rates.
- There were plans to increase the services offered by diabetes specialist nurses in the community as part of CQUIN targets. Specialist nurses were concerned this would affect the delivery of their services to inpatients.
- Leaders in the infectious diseases team had clear plans for the future delivery of their services. A business case had been developed to introduce a PICC line service to improve patient care and experience.

Governance, risk management and quality measurement

- The division of medicine had a divisional governance lead. Quality and performance meetings were held within the division and this was in turn fed up to the trust wide quality and performance committee. Divisional governance leads met together to share learning across divisions.
- There was a new risk management strategy being implemented in the trust. Medical services had an overall risk register with each directorate having its own risk register.
- The management team did not have a clear oversight of all the risks within medical services. For example, no actions had been taken to mitigate risks in relation to infection control and there was no plan in place to manage wards sharing facilities or staff in the event of an outbreak of infection. Similarly, there had been no risk assessment regarding the four continuous cardiac monitored beds on MEU specifically in relation to staff training and staffing levels. When we raised this with the trust, they carried out a risk assessment and recognised that this was unsafe.
- Although the use of the MTC for inpatients stays was identified on the risk register, there was no formal risk assessment in relation to the use of this facilitiy overnight and no consideration had been made to infection control issues or the lack of facilities for patients.
- The division was aware of difficulties with access and flow throughout the urgent care pathway; however they did not collect key information about the use of

escalation beds and the use of MTC to house inpatients overnight or patients following surgical procedures. This meant that they did not have a sound understanding of when additional bed capacity was required or used.
- The trust did not recognise when mixed sex breaches were occurring at the MTC and therefore did not monitor or report this through formal mechanisms.
- Staff saw the importance of audit and governance, but felt that too much time was taken away from caring for patients and this was frequently about ticking boxes rather than caring for patients.
- Audits recognised the need for improvement to patient care but in some cases, audit results deteriorated rather than improved. There was insufficient oversight of this from a senior level.
- Nursing metrics were completed once per month to improve the quality care and treatment. Results were feedback to ward managers and matrons.
- On a quarterly basis the division held confirm and challenge meetings to discuss performance such as serious incidents, staffing and service developments. From the minutes we reviewed key themes had been identified and actions, however there was no evidence to deomstrate how these actions were going to be monitored. This meant it was unclear how improvements were going to be made.

Leadership of service

- Many of the leaders at ward level were new in post and therefore local ward level leadership was in its infancy, although staff told us that the new leaders had been a positive development. Local leaders told us about work they were beginning to complete to involve staff more in service improvements.
- There were mixed views on the overall leadership of nursing in medical care. Band 8a nurses felt supported by the lead nurse, but band seven and six nurses felt that the leadership from this level was blame focussed and not supportive. They told us they tried to shield more junior members of staff from this leadership style.
- One nurse told us that junior staff were worried about being honest with our inspection team but hoped that our team saw "what was really going on". Band seven nurses told us that they felt they could not be honest during our focus group as their immediate managers were also in this group and they were worried about any repercussions.
- Senior nurses told us that they rarely received positive feedback. They told us that email communications were negative and felt that managers were looking for fault in their work rather than giving praise for good work. Band seven nurses told us they found this approach upsetting and it was not uncommon for this to reduce them to tears.
- Staff told us that there had been a positive change in the overall leadership of the trust in the past 18 months. The chief nurse regularly visited wards, but senior nurses told us it was difficult for staff to feel positive about this as they were worried she would leave the trust. We were told that changes in the leadership and management of medical services and the trust had been so frequent it was difficult for staff to understand and follow the vision for the service.
- Medical staff told us they had a good relationship with the divisional manager and he was seen daily. They told us that there was less discussion or involvement regarding operational decisions made by non-clinical managers, for example the closure of beds and the introduction of MEU beds on the neighbouring respiratory ward. They felt that the multiple changes in directorate management meant that service changes and improvements were hard to deliver.
- Specialist nurses had good links across all four hospital sites and held bi-monthly meetings with nurse consultants.
- Allied health professionals told us that managers were supportive and approachable.
- Staff told us that systems and processes between the four trust sites were different and this could be frustrating at times.

Culture within the service

- There was a booklet celebrating successes across the trust. In addition to this, the Monday message from the chief executive highlighted examples of good care and practice. Ward E3 were proud to have been mentioned in the Monday message three weeks running.
- Staff told us that there had been a culture of bullying on some of the medical wards in the recent past and that staff attitude had been poor. We were told of one member of staff who needed additional support with competencies, who had felt she was unable to ask for support. They told us that this was now improving but that it was difficult to challenge poor behaviour as this was then interpreted as bullying. Senior nurses told us

that the human resources team supported them with this. We were told that there were agency staff who did not want to work on some medical wards due to staff attitude.
- Staff told us that there was a feeling that when things went wrong, there was a culture of blame and there was "finger pointing"
- We were told that the culture had become more patient focussed in recent months. There was a view that care was a "tick-box" exercise in the recent past.
- Some staff told us that they were uncertain about the future of the trust and the hospital and that this caused them some anxieties. There was speculation and concerns regarding the announcement that the chief executive was leaving.
- Staff sickness absence rates during the eight months to December 2015 was 4.8%. The turnover rate during 2014/15 was 10.6% for qualified and unqualified nursing staff. There were high levels of staff sickness on some medical wards. On one ward, three members of staff were on long term sick leave due to work related stress.
- The latest staff friends and family test results for January 2016, show that 70% of staff would recommend the hospital as a place to be treated and 57% of staff would recommend the hospital as a place to work.
- In the 2015 staff survey, the trust scored in the lowest 20% of acute trusts for the percentage of staff experiencing bullying or harassment from other staff, support from their immediate managers and for experiencing discrimination at work.

Public engagement

- There were open and honest care boards including "you said, we did" information displayed on each ward. These boards displayed comments received from patients and planned or actual changes made as a result of these.
- Patients were involved in patient led assessments of the care environment (PLACE) visits and were invited to listening into action focus groups throughout the year.
- Response rates to the FFT were higher than the England average of 33.7% throughout the trust, but were particularly high on CCU, J3 and F4/PIU (all higher than 64%). This meant that patient feedback was received from high numbers of patients.

Staff engagement

- Ward meetings were held monthly. Minutes were taken and circulated to all staff. The Monday message was a weekly email from the chief executive including essential updates and also celebrating achievements.
- In 2014, the 'chief executive's challenge' was introduced. Staff were asked to be involved in developing the trust vision and values. This challenge received 27,000 ideas from the workforce. Staff had also been asked to give their views on reducing sickness absence rates. The development of the trusts "healthy, happy, here" programme was the result of the 44,000 contributions. The third challenge had recently been completed and led to the development of the 10 "raising the bar on quality" actions.
- Staff awards were held annually, recognising team and individual staff patient care, dedication and innovation. The Ebola task and finish group (part of the ID service) had won the patient safety award in 2015.

Innovation, improvement and sustainability

- Leads within the medical division were involved in urgent care improvement groups with membership from across the trust, local authority and CCGs. There were identified work streams addressing issues such as admission avoidance, discharge planning, readmissions and the workforce. There were plans in place to speed up assessments by social services using a single trusted assessor when patients were in a hospital out of their local authority area. The trust was also looking at new ways of working, for example using pharmacy technicians to complete medication rounds to reduce the number of medication errors.
- The division of medicine had undertaken a 'perfect week' project in June and July 2015. This project identified a number of areas for improvement and actions to be taken as a result of this to improve patient flow, safety and experience.
- The infectious diseases team were involved in a range of research projects. This was an innovative team who had developed their services in response to the needs of their particular patient group. For example, there was an online encrypted portal to allow secure access to HIV test results. They recognised the need to extend the service within the wider community of Greater Manchester and were looking at ways to involve primary care to ensure a sustainable service in the future. One of the ID consultants had recently been awarded

investigator of the year at the Greater Manchester clinical research awards and the lead pharmacist for HIV had been awarded an excellence in practice award at the HIV pharmacy association awards.

Surgery

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

Information about the service

North Manchester General Hospital (NMGH) is the largest hospital within the trust and is located in Crumpsall, 3.5 miles north of Manchester city centre. The site is also home to the trust's main headquarters.

The hospital has a full accident and emergency department, which includes a separate paediatric accident and emergency unit. It offers a full range of general and acute surgical services. From July 2014 to June 2015, 20,600 patients attended surgical services at NMGH.

The principal surgical services include: General surgery; Orthopaedics; Ear, Nose and Throat Surgery; Dental; Ophthalmology; Urology and Gastroenterology

During our inspection, we visited the orthopaedic theatre and day case theatre areas, the preoperative surgical service, the surgical triage ward and four inpatient wards, D6, F3, I5 and F5N.

We spoke with 13 medical staff, 38 nursing staff, including managers, 21 members of the multi-disciplinary team, six patients and four patients' relatives.

Summary of findings

Overall, surgical services were rated as requires improvement.

- We found that surgical services were caring and responsive. However, improvements were required to make them safe, effective and well led.
- Sepsis management and associated processes were implemented in June 2014. However, since June 2014 there was limited staff uptake in sepsis management training. To-date, 4% of nursing staff had attended this training.
- Trust sepsis management guidance was not followed on one occasion on ward I5, as prescribed antibiotics were not given within an hour of being prescribed.
- Outliers were located throughout the surgical service. This relates to patients who were situated away from the speciality they should have been admitted to. Concerns were also identified that patients placed on general surgical wards or outliers were not reviewed daily.
- Not all staff understood the legal requirements of the 'Mental Capacity Act 2005' and 'Deprivation of Liberties Safeguards.'
- There were no formal surgical service strategies were not in place.
- Newly implemented governance, risk and quality measurement processes were in place, which meant that learning and monitoring processes from governance and quality measurement processes might not be as robust as they should have been.

Surgery

- Some of the staff we spoke with identified that their knowledge of the trust core values and what they involved was limited.

However:

- Care was provided in line with NICE CG50. Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.
- Systems were in place to ensure that risks to elective and emergency patient groups were identified pre-operatively, for example, venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission. Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%.
- We observed visibly good infection prevention practices by staff and noted good compliance in this area.
- Clinical equipment had been serviced. Daily checks of resuscitation equipment took place. However, we observed that these checks were not robust as three pieces of the resuscitation equipment had no expiry dates on the packaging or were identified on the resuscitation checklist. This finding was immediately escalated to the nurse in charge who replaced the equipment.
- Consent processes were generally robust and documentation associated with these processes adapted to the individual patient's needs and understanding. The records we reviewed showed that consent was taken correctly.
- There was good access and flow to services, which met patient's needs. Service developments had improved patient access to treatment.
- Patients received evidenced based care, treatment and patient outcomes were good. Good multi-disciplinary working existed between the trust, surgical day service, local clinical commissioning groups and community services.
- Staff were caring, compassionate and respectful.

Are surgery services safe?

Requires improvement

Surgical services at North Manchester General Hospital (NMGH) required improvement.

- Sepsis management and associated processes were implemented in June 2014. However, since June 2014 there was limited staff uptake in sepsis management training. To-date, 4% of nursing staff had attended this training.
- Trust sepsis management guidance was not followed on one occasion on ward I5, as prescribed antibiotics were not given within an hour of being prescribed.
- Shortfalls in staff attendance at infection control (patient handling) training for 2015 were observed. Trust training statistics confirmed that 80 to 82% of nursing and medical staff attended this training.
- An undated training summary was provided for mandatory training attendance. We noted that training attendance levels ranged from 0% to 93% for the nursing and medical staff groups identified. The main training attendance shortfalls documented related to adult life support training's, sepsis six, mental health training, medicines management and complaints.
- Expiry dates were not identified for the adult re-breathe mask or basic life support pocket face mask and the Callisto laryngoscope blades (size three and four) on the resuscitation equipment checklist for the pre-operative clinic and surgical triage unit. The lack of expiry dates on this equipment was escalated to the nurse in charge of each unit. We revisited the preoperative assessment unit later and saw these items were replaced.
- Two yellow clinical waste bins were found unlocked in the main corridor outside ward I5.
- Gaps in monitoring of drugs fridges were found in the general surgical theatres.
- The policy for the ordering, storage and administration of controlled drugs (CD) (EDC017) had expired on 1 February 2016; its review date was identified as 1 August 2016. Normally the review date would be identified before the expiry date. Since the inspection the trust had confirmed a new policy was at the time of the inspection awaiting upload to the Document Management System

- We were unable to ascertain whether all relevant surgical staff had completed level three safeguarding training, as training statistics for staff attendance were not provided by the trust.
- Formalised induction checklists did not exist to document induction processes for bank or agency staff who worked on the clinical area for the first time.
- Staffing concerns were identified on ward D6 and F5 due to patient acuity being too high for staffing levels. However, staff on F5 felt assured by the chief nurse's involvement in their concerns and the proposed actions to recruit additional nursing staff.

However we also found:

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incident management was in line with 'being open' and the 'duty of candour.' The 'duty of candour' is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust introduced the 'Open, Honest Care Board' in February 2016 to clinical areas as a method of communicating monthly clinical performance and staffing data.
- Equipment monitoring systems were in place and clinical equipment had been serviced.
- The chief nurse had submitted a nurse acuity staffing review paper (November 2015) to the trust Board in December 2015. The review noted that operating theatres were established against the 'Association for Perioperative Practice (AfPP) staffing recommendations and were currently under review. Medical and nursing staffing levels and skill mix reflected current guidance.
- Care was provided in line with NICE CG50. Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.
- Systems were in place to ensure that risks to elective and emergency patient groups were identified preoperatively, for example, venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission. Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%.
- Systems were in place to ensure that the '5 steps to Safer Surgery - World Health organisation' (WHO) surgical safety checklist was completed for patients prior to and following surgical intervention.

Incidents

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Medical and nursing staff said they knew how to report incidents and had received feedback. Incident feedback was cascaded through email, staff meetings and during the ward daily safety huddles. Other forums in which incidents were discussed included governance meetings, speciality audit, and during the division of anaesthesia confirm and challenge meetings.
- Staff told us that safety alerts were circulated via email, the general manager and risk department; relevant alerts were discussed at the directorate governance meeting.
- The trust 'Incident Reporting & Investigation Policy including Serious Incident Framework and Duty of Candour (EDQ008)' was in line on 'being open' and the 'duty of candour.' The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Following the launch of the new incident policy in 2015, a power point presentation and frequently asked questions document for staff was circulated trust wide.
- Data from 'Strategic Executive Information System' (STEIS) dated from December 2014 to November 2015 confirmed 20 serious incidents (SI) for surgery were reported at North Manchester General Hospital (NMGH) from December 2014 to February 2016. Three serious incidents took place in December 2014; two SI's were due for final sign off by the local clinical commissioning group (CCG). The other SI had an external investigation commissioned and was waiting for confirmation the extension request sent to the CCG was agreed. We noted that the 20 SI's had been investigated or were under investigation. Comprehensive incident reporting forms identified lessons learned, recommendations, arrangements for sharing learning from the investigations and action plans.
- The surgical incident register recorded all incidents for all specialities and locations within surgery. Incident

dates for NMGH were dated from 1 December 2014 to 30 November 2015. Each incident identified its cause and impact. Two of the highest themes identified were falls and patient accidents and incidents. The majority of impact ratings assigned to incidents were no harm incidents.

- Mortality and morbidity review meetings are a forum where in-hospital deaths are reviewed. Staff told us that mortality reviews had recently been introduced and mortality and morbidity meeting minutes were now being documented and findings discussed at the monthly safety committee. We saw an example of this in practice through discussions and learning relating to mortality and morbidity in minutes from the trust wide 'Upper GI/Colorectal Surgery Governance/Clinical Audit Meeting (23 September 2015).'
- We saw a selection of minuted speciality mortality and morbidity meetings, which had taken place. We were told that the learning from these meetings was disseminated within the team and throughout the trust. We saw learning and discussions had taken place in the trauma and orthopaedic teams morbidity & mortality meeting minutes dated 23 October 2015 and within the teams November 2015 orthopaedic presentation.
- The December 2015 'Integrated Performance Report', identified mortality rates were relatively good as the service hospital mortality indicator (SHMI) remained above 1.00 and was within the expected range. Hospital standardised mortality rates (HSMR) were noted as good compared to peers (3rd best in the North West).

Duty of candour

- The trust identified that there had been no formal training on 'duty of candour', although it was covered in a training video, which could be accessed by staff. The trust-identified statistics, which identified the total number of staff who had watched the training video, were not collected. The head of patient safety confirmed that a 'duty of candour' policy was in place and recently a staff guide for 'duty of candour 'had been launched and disseminated across the trust to staff groups. The trust identified that some staff had attended this training in June 2015.
- The trust's 'Pride in Safety' winter newsletter identified guidance for staff on what they should do in relation to 'duty of candour – Being Open With our Patients and their Families.'
- We asked seven staff about their understanding of the 'duty of candour' regulation. The 'duty of candour' is a regulatory duty that required providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This included giving them details of the enquiries made, as well as offering an apology. When asked four staff was not aware of this regulation, whilst three staff demonstrated some awareness of the duty of candour regulation and what it involved.

Safety thermometer

- The NHS safety thermometer is a national initiative. A local improvement tool used to measure, monitor and analyse patient harm, and harm free care. A monthly snapshot audit of avoidable harm included falls, new pressure ulcers; catheter related and urinary tract infections (CUTI) was provided. The Care Quality Commission pre-inspection document for surgical services trust wide (January 2016) summary of analysis identified a steady rise in the number of pressure ulcers, four per month, reported between December 2014 and March 2015 and in December 2015. Low numbers of falls with harm were reported averaging two per month, whilst catheter acquired infections averaged one per month.
- The trust safety thermometer data from November 2015 until January 2016 mostly confirmed that 100% harm free care was achieved for surgical areas at NMGH. However, some shortfalls were identified in four clinical areas where care had resulted in harm. The areas of harm identified were patient falls, new pressure ulcers and a new venothromboembolism (VTE). The data confirmed that ward I5 had the highest number of harms identified for November and December 2015. In addition, we observed the safety incident data identified ward I5 as having had the highest number of incidents from November 2015 to January 2016.
- The trusts December 2015 'Integrated Performance Report' confirmed the highest priority trust wide harms were pressure ulcers and falls. A pressure ulcer reduction action plan was in place and 'falls' were part of the Trust Safety programme. A falls policy, falls safe bundle and ward based 'falls safety champions' were implemented to improve patients' outcomes. The new falls-safe bundle was completed in one patient's nursing notes we reviewed.

- A venothromboembolism (VTE) assessment was completed for hospitalised patients within 24 hours of admission. The 2015 trust audit data confirmed compliance as 96% and 97%for the completion of VTE assessments, against the trust target of 95%. Elective surgical patients were risk assessed pre-operatively and the assessment reviewed on admission. We noted from six patients' peri-operative documents completion of VTE assessments. An additional three patient notes confirmed that assessment reviews had taken place within 24 hours of admission.
- Patient safety at the trust was overseen by the patient safety team whose safety programme focused on the profile of incidents and complaints and whether the early warning score featured in the incident.
- Monthly clinical performance and staffing data was reported on the 'Open, Honest Care Board' introduced in February 2016 to clinical areas. On ward F5 for February 2016, we observed there were no pressure ulcers, multi resistant staphylococcus aureus or clostridium Difficille episodes reported. On ward I5 the February data recorded on the 'Open, Honest Care Board' included, two pressure ulcers, two falls, two compliments and one complaint. By presenting data in this way, this showed the service kept patients and relatives informed about clinical performance and staffing issues.

Cleanliness, infection control and hygiene

- Surgical wards had an infection control 'link' staff member. Staff told us they could easily contact the infection control team, which meant appropriate professional advice was available.
- Staff throughout surgical wards, the pre-assessment clinic and theatres observed good infection control practices. We observed the use of personal protective equipment and hand sanitiser by staff. Hand sanitiser was located on entry to each clinical area and within clinical areas. However, staff identified concerns that the infection control status of patients was not always clearly indicated on side rooms.
- One patient said they had observed medical and nursing staff washing their hands and the ward (I5) was very clean.
- Staff received infection prevention and control training as part of their induction and at mandatory training. Staff confirmed completion of the yearly mandatory on line infection control training. The service training statistics for 2015 - 2016 confirmed that 91% of nursing staff had completed infection prevention (non-patient handling) training. Whilst, infection prevention (patient handling) training attendance figures showed attendance by 80% - nursing and midwifery staff and 82% -medical and dental staff.
- Cleaning schedules were in place, which identified the tasks and frequency of cleaning in each area. The cleaning schedule on F5 identified which daily checks were required. For example, oxygen points, suction, bedframe. We saw that each area was ticked as completed, however, there was no date recorded to indicate when these checks had taken place.
- Monthly environmental cleaning score audits for nurse, midwife and healthcare assistants (HCA) had taken place throughout 2015. The minimum average target for the trust and per site was 88.5%, which is a green status. The trust environmental audit report (SUR8) identified cleaning scores for nursing, midwives and HCA staff at NMGH as 89%. Monthly data provided from April 2014 to October 2015 for NMGH confirmed achievement of amber and green status. The monthly cleaning scores were between 85% to 95%. Green status was achieved for 12 of the 19 months audited.
- The monthly cleanliness scores for computer equipment at NMGH from April 2014 to October 2015 had an identified green status with scores between 97 to 100%.
- 'Infection prevention – an information guide' (February 2014) is a leaflet available for patients and visitors. The leaflet informed them of the measures to take to prevent infection. Details of what to expect from staff infection prevention practices were also identified for patients. The leaflet is available in English but can be obtained in other languages; details of how to obtain them in another language were included within the leaflet.
- Pre-operative assessments including 'Multi resistant staphylococcus aureus' (MRSA) screening of patients took place approximately 12 weeks prior to scheduled surgery and was documented in patients notes.
- Staff from ward I5 said that approximately four patients had returned to theatre because of surgical site infections in the previous 12 months.

Environment and equipment

- Equipment suitable for patients was seen in all clinical areas.

- We checked some equipment throughout the service and saw stickers with dates confirming that maintenance checks had taken place.
- Generally, we found that resuscitation equipment on the surgical wards and theatres were in date. Resuscitation equipment was reviewed on the pre-operative assessment unit, the surgical triage unit, orthopaedic and general surgery theatres and admissions ward.
- The resuscitation trolley on the admissions unit was untagged. Staff told us this was because the resuscitation officer had asked staff not to tag the resuscitation trolley. However, we observed that resuscitation trolleys in the other areas we went to were tagged. We discussed this with staff and referred to the trust resuscitation policy (v6.2 - EDC015). The trust resuscitation policy did not identify whether resuscitation trolleys should be tagged.
- Resuscitation monitoring records confirmed resuscitation equipment within resuscitation trolleys were checked daily. Defibrillator monitoring records confirmed weekly checks took place for this piece of equipment.
- We observed the resuscitation equipment checklist and equipment as listed for the pre-operative clinic and surgical triage unit did not include expiry dates for the adult rebreathe mask or basic life support pocket face mask and the Callisto laryngoscope blades (size three and four). The lack of expiry dates on this equipment was escalated to the nurse in charge of each unit who arranged for replacement of these items.
- The Callisto laryngoscope blades were not identified on the preoperative assessment unit's checklist. This was escalated to the nurse in charge who confirmed they would escalate these omissions to the trust resuscitation officer. We revisited the pre-operative assessment unit later in the day and saw that these items were replaced.
- Appropriate measures were in place to maintain security. Security cameras were located throughout the building and people either had to ring a bell to enter the clinical environment or use password access.
- Prior to patient's appointments they could arrange to use a hospital wheelchair to assist their mobility.
- On entering the corridor by ward I5, we observed two yellow clinical waste bins were unlocked.
- The 'hospital sterilisation and decontamination unit,' (HSDU) was located in J block at NMGH which provided a decontamination and sterilisation service for medical devices. This ensured that on a daily basis, the surgical service met its operational targets within the quality standards. Staff said they had experienced no problems with the turnaround or flow of equipment from the HSDU.
- Dietetic staff told us that they arranged patient's nutrition equipment prior to the patient's discharge to ensure the patient had the necessary equipment in place when they arrived home.

Medicines

- Medicines management was in line with trust policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys. We reviewed three patients' drug charts and no gaps were seen against the entries.
- The policy for the ordering, storage and administration of controlled drugs (CD) (EDC017) had expired on the 1 February 2016; its review date was identified as the 1 August 2016. Normally the review date is identified before the expiry date.Since the inspection, the trust confirmed a new policy was awaiting upload to the document management system.
- The controlled drugs (CD) policy identified daily CD checks should take place. We reviewed the CD books from orthopaedic theatres and ward I5 and saw that daily checks of CDs took place.
- A dedicated pharmacist and pharmacy technicians support theatres and clinical areas. Out of hours (OOH), staff told us they could access an OOH cupboard located in pharmacy and could call an on call pharmacist for advice and support.
- Staff from I5 told us that medicines management was provided through an electronic medicines system. When drugs were not given or given late the system identified the drug by displaying an alarm clock alert. The system would not allow drugs to be given before they are due when frequency of times to be given had been identified.
- We observed a nurse giving a patient medication that was due to be transferred to another hospital. The medication was given so that it was not delayed by their discharge. The medication was given and documented on the electronic prescribing system so that the medication could not be given again at the new hospital.

- We found gaps in drug fridge monitoring records in the general surgical theatres. Eleven checks were missed in January 2016 and eight checks missed in February 2016.
- Staff told us that they tried to pre-empt patients for discharge at weekends and where necessary they could dispense patient's medication to take home from the ward.
- Nursing and medical staff received medicines training at induction. Training statistics provided by the trust confirmed that 36% of nursing staff and 2% of medical and dental staff had completed medicines management training.
- A trust wide antimicrobial point prevalence study was completed in July 2015. The outcome showed that antimicrobial prescribing within the trust was good. Three work streams were identified which included a repeat of this audit in January 2016. We reviewed six patients' records, which confirmed their antibiotics were reviewed.

Records

- Computerised patient records were password protected. Staff said they had individual passwords to allow them to access patient information.
- Records were stored securely in the clinical areas we visited. (F3,F5, D6, I5)
- We reviewed a mixture of 19 sets of medical and nursing notes. We saw completed pre-operative assessments, pre-operative checklists, consent documentation, correct site surgery sheets, perioperative records, surgical safety checklists, post-operative care records and discharge dates and times logged for those patients discharged home.
- In line with the Royal College of Surgeons 'Good Surgical Practice (2014) staff told us that pre-operatively patient concerns and / or needs were discussed within the multi-disciplinary team at the patient's pre-admission visit. For example, a patient with safeguarding needs or complex needs would be identified prior to surgery so that the necessary support could be identified for that patient.
- Risk assessments were completed in the nine patient's records we reviewed. The types of assessments completed for one patient included those for pressure ulcer, falls, MUST and venous thrombus embolism (VTE). For each of these assessments we noted that rescreening had been completed at the identified screening frequency.
- Patients care plans reflected their needs, were reviewed and seen to link with the patients risk assessments.
- Staff completed the '5 steps to Safer Surgery - World Health organisation' (WHO) surgical safety checklist for patients prior to and following surgical intervention. We reviewed five patients' surgical safety checklists and saw they were fully completed on-line and on paper in patient notes.
- The trust confirmed that records audits had taken place across the surgical service. We reviewed one records audit regarding a 'Trust-wide re-audit of Anaesthetic Record Keeping 2014', which showed shortfalls in documentation for NMGH. The trust target included the review of 30 sets of notes per hospital site; at NMGH 32 cases were reviewed which included nine major and 23 minor cases.
- The recommendations from this audit identified 1) the current anaesthetic record should be reviewed against the requirements of the trust essential record keeping standards, and amended as necessary. 2) Education around the importance of good quality record keeping, particularly in terms of protection in terms of medico legal cases. 3) Action plan to be developed at the Clinical Audit & Governance Meeting March 2015 / May 2015.
- An updated action plan for the '2014 Annual Anaesthetic Record Keeping Audit' was seen which identified six actions, all were in progress and progress updates identified. For example, one progress update identified that the new anaesthetic charts were being circulated across all sites to commence pilot. From the information provided, we could see that learning had resulted in review and changes to the existing anaesthetic record.

Safeguarding

- A trust safeguarding team advised on adults safeguarding concerns. The team had identified nursing staff for specific areas, for example, adult safeguarding, deprivation of liberty safeguards, dementia, learning disability and tissue viability.
- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide. The annual safeguarding adults and children

report (2014 / 2015) provided assurance to the trust board that the necessary safeguarding framework was in place and continued to develop to ensure that the welfare of children and adults at risk was promoted and protected within the Trust. This report also ensured that the trust continued to fulfil its statutory obligations in relation to safeguarding.

- Staff told us they had effective working relationships with the local adult safeguarding teams and other healthcare professionals such as social workers and community nursing staff.
- Staff said the safeguarding team could be accessed by telephone for advice. In addition, they could easily access support from the mental health nurse and the rapid access in dementia team for those patients who required this support.
- Staff demonstrated knowledge of the safeguarding guidance to follow, knew what to do and who to contact should a concern be raised.
- Staff told us that concerns about safeguarding issues were also recorded on daily and weekly safety huddle documentation so that staff were informed of current issues.
- Staff completed children's and adult safeguarding training at trust induction and during core mandatory training sessions. The trust identified that medical staff and nursing staff at band six and above completed level three safeguarding training. Training statistics for staff attendance at level three safeguarding training were not provided by the trust.
- Training statistics for surgery for 2015 to 2016 confirmed that 93% of nursing and midwifery staff and 92% of medical and dental staff had completed level two adult safeguarding training.

Mandatory training

- We spoke with members of staff of all grades, who confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, resuscitation, fire safety, manual handling, infection control, and safeguarding.
- Internet based mandatory training included training sessions in fire awareness, basic life support and hand washing training sessions are completed yearly by staff. In addition, other core mandatory training sessions include information governance, equality and human rights, infection prevention for handlers, movement and handling for patient handlers and clinical waste segregation.
- The trust's target for mandatory training compliance was 90%. The information received from the trust identified training attendance compliance levels by staff for individual training courses. An undated training summary was provided for mandatory training attendance. We noted that training attendance levels ranged from 0% to 93% for the nursing and medical staff groups identified. The main training attendance shortfalls documented related to adult life support training sessions, sepsis six, mental health training, medicines management and complaints.
- Training statistics provided by the trust confirmed that 84% of nursing and midwifery and 62% of medical and dental staff had completed basic life support training in 2015 to 2016. Staff attendance at intermediate life support training sessions were, nursing 7% and medical and dental staff 12%. In addition, 25% of medical and dental staff and 2% of nursing and midwifery staff had completed advanced life support training.
- Training statistics for 2015 identified that 82% of orthopaedic theatre staff had completed mandatory training.

Assessing and responding to patient risk

- Senior staff told us that there had been a focus on sepsis management and training. In June 2014, the trust reviewed the sepsis policy. However, the sepsis policy was not discussed at the patient safety programme board until January 2016.The sepsis improvement plan timescales for completion of actions were identified from July 2015 to 31 March 2016. Some actions identified on the plan included the development of online sepsis training, patient screening and antibiotic administration. Training statistics provided by the trust confirmed that to-date, 4% of nursing and midwifery had accessed sepsis training.
- On ward I5, we observed a patient who was on the sepsis pathway. The patient had antibiotics prescribed at 9.55am, however the antibiotics were not given until 11.30am due to the patient being allowed to go to x-ray. We escalated that the antibiotics were not given to the

nurse in charge, who arranged for them to be given. The antibiotics were given by the nurse in charge. We also escalated this to the ward sister so that they could ensure that appropriate actions were taken.

- The service had identified guidelines and protocols to assess and monitor patient risk in real time, and respond to changes in risk level.
- Staff from ward D6 told us that their patients stayed in the high dependency unit following surgery for at least two days were now discharged back to the ward the day after surgery. The impact of these earlier discharges was that these patients were requiring 1:1 nursing care, which generally used two trained staff.
- Staff told us of two incidents were patients were nursed in the theatre recovery area rather than the high dependency unit (HDU). This was because the HDU beds, which were originally allocated to them, were given to other patients admitted through the emergency department. On both occasions, an anaesthetist and recovery nurse stayed with the patient until the patient was transferred to the ward or HDU. We were told that two recovery staff had completed the critical care course.
- The trust confirmed three occasions in the last 12 months where patients were cared for in theatre recovery. Incident forms were not completed for these occasions but the new process meant delayed transfers from theatre to critical care would be highlighted through an incident report.
- The trusts actions included the establishment of a working group and development of an action plan to ensure that measures were in place to prevent this from reoccurring. The working group comprised of theatre, critical care and ear, nose and throat clinical and management staff. Theatre and critical care managers now met regularly to review the above measures and also attended the weekly theatre resource meeting were potential patient needs for elective surgery were discussed. Individual patient's surgery is not started without a bed being available and the critical care bed was ring-fenced once surgery had commenced. Senior staff told us that these measures were discussed at the divisional senior management team meeting.
- Senior staff identified theatre recovery staff did not receive level three critical care training as a mandatory training requirement. If staff were nursing a level three patient in recovery, an anaesthetist trained in level three care would assist with the patients care. A level three patient is a patient who requires advanced respiratory support alone or basic respiratory support together with support of at least two organ systems.
- The early warning score (EWS) is a tool used to monitor patients who may be at risk of deterioration by grading the severity of their condition and prompting nursing staff to ask for a medical review at specific trigger points. The tool was incorporated into the physiological observation chart with track and trigger early warning system scoring system guidance located on the back of the physiological observation chart.
- For patients with an early warning score above three and awaiting urgent medical review this would be communicated to staff coming on shift during the 'safety huddle' session at the start of the shift.
- Risks to patients were initially identified during their initial assessment by staff at either Royal Oldham Hospital or Fairfield Hospital and these needs identified within care plans and risk assessments.
- During our theatre observations we observed staff complete the '5 steps to Safer Surgery' World Health organisation (WHO) checklist for patients, prior to and following surgical intervention. These checklists were recorded on-line and on paper in the patient notes. The staff involved were seen to stop, listen and were engaged in this process. We reviewed five completed safer surgery checklists.
- Clinical areas had resuscitation link nurses who attended the six monthly trust resuscitation meetings. These link nurses responsibilities included feedback of changes to do with resuscitation to the nursing staff.

Nursing staffing

- The chief nurse had submitted a nurse acuity staffing review paper (November 2015) to the trust Board in December 2015, which identified actions, requested, corporate priorities, risks, development and assurance and resource implications. The review noted that operating theatres were established against the 'Association for Perioperative Practice' (AfPP) staffing recommendations and that this was currently under review.
- Senior staff told us that the staffing followed NICE guidelines SG1. Staffing escalation guidance was in place to ensure safe staffing levels were maintained. Two staff confirmed satisfaction with current staffing arrangements.

- One staff member identified that head and neck surgery funding finished at 8pm, after this staff were paid over time rates. Senior management were aware of this staffing budget shortfall and were looking into this.
- Each surgical area had an identified funded staffing establishment and staff rotas were produced through the electronic e-rostering system. Senior staff told us there was some flexibility within the ward funded establishments in that additional staff could be employed within a pay band as long as the monies were taken from another pay band, which was not fully recruited to.
- Senior staff said an acuity tool was used during the 2015 staffing review of ward I5. The review identified an extra five band five nurses were required on top of the existing staffing establishment. This was agreed and monies were released to enable recruitment to take place. Since the staffing review an extra three band five nurses were recruited. Staff said existing staffing levels on ward I5 were considered as safe and a day coordinator was on shift Monday to Fridays. Three band six trauma coordinators who undertook coordination and bed management duties provided additional staffing support. Following staffing reviews, a bed reduction was agreed on ward I5.
- Staff expressed concerns on staffing levels from two clinical areas, D6 and F5. One staff member from D6 said that over the last six months staffing had been dangerous because patient acuity was too high for staffing levels. A recent incident was identified where the staff member had completed an incident form detailing the situation and had submitted the incident form. Staff said that a nurse coordinator role did not exist on D6 because staff who took change of the ward also took patient caseloads.
- On ward F5, concerns about staffing levels were identified by three staff. The concerns related to staffing levels being insufficient for patient caseload and acuity, staff unable to take breaks and going home late from shifts. Staff said these staffing shortfalls were recognised by senior management, beds on the ward were reduced to 19 beds in total and bank staff brought into assist on the ward. In addition, two band two healthcare support workers were about to start work on the ward.
- Staff described the staffing escalation route taken when staffing shortfalls existed. The staffing escalation route was described from ward level to the chief nurse. The staff on F5 had used this escalation route to inform the chief nurse of their staffing concerns. A letter dated 17 February 2016 was seen addressed to the staff from the chief nurse in response to their recent concerns about staffing shortfalls. The outcome was to arrange a staff meeting with the chief nurse. Staff said they felt assured by the chief nurse's involvement and the staffing proposals to recruit two healthcare support workers in the future.
- taff said once daily patients transfer from theatre recovery was delayed due to the surgical wards having insufficient staff to take the patient.
- Theatre staff confirmed that a band seven nurse led each theatre team. These teams were the emergency team, head and neck and pain clinic team, urology team and the recovery team. We were told that the maternity theatre team had recently joined the head and neck and pain clinic team. Senior staff said that they currently had five staff vacancies in the theatre department. In the interim two long-term agency staff were being used to provide additional staffing resource.
- Staff told us that all staff including temporary staff completed inductions to the clinical areas. However, we were told that there was not a specific induction checklist for use when bank or agency staff worked on the clinical area for the first time.
- We observed a nursing handover session on ward F5. The session was informative and patients discharge plans were discussed.

Surgical staffing

- Health and Social Care Information Centres (HSCIC) statistical data from September 2004 to September 2014 showed that the proportion of consultants was 39% compared to the England average of 41%; middle career doctors were 19% compared to the England average of 11%. The registrar group was 27% compared to an England average of 37%, whilst the proportion of junior doctors at the trust was 15% compared to an England average of 12%.
- The service had similar levels of junior grade doctors and higher levels of consultants compared to the England average. (Pennine Acute Hospitals NHS Trust pre-inspection document, January 2016). The surgical wards and theatres we inspected had a sufficient number of medical staff with appropriate skill's to ensure that patients received safe care.
- We were told that each surgical speciality had 'hot week' teams. For example, the general surgical team work a

'hot week' where they do not undertake elective theatre lists. Their remit this week is to undertake emergency work only. Consultant staff work a 12-hour shift pattern. Currently two consultant teams covered NMGH and Oldham Hospital.
- Staff said there was no trust specific induction for locum junior doctors.
- Junior staff said they had confidence in the consultant staff.
- Junior doctors in their first year told us they were ward based. Foundation year two (FY2) doctors and senior house officers were team based and provided treatment in wards areas, theatres and outpatient clinics.
- Staff told us that the FY2 doctors rarely get a break, as they were very busy on the wards. This had been recorded in documentation, which confirmed hours worked by FY2 doctors. We were not told what outcomes had resulted from this monitoring process.
- Staff told us that staffing levels in theatre were good.
- We spoke with two long-term locum doctors who confirmed they had completed an induction and had clinical supervision support.
- Out of hours, emergency on-call rotas were in place. In addition, 24-hour consultant led care was available for the general surgical and orthopaedic specialities.
- Medical handovers took place in the surgical treatment centre twice daily.

Major incident awareness and training

- A Service Continuity Policy and Strategy' to ensure critical services are delivered in exceptional circumstances is in place. (v2.3, reviewed January 2016).
- Action cards for each clinical area support the major incident plan for North Manchester General Hospital (version 5, 3 February 2015). The plan details the procedures to be implemented should a major incident or a HAZMAT (Hazardous Materials) / C.B.R.N.e. (Chemical, Biological, Radiological, Nuclear, Explosives) incident occur.
- This plan identified staff specific roles and the measures should a major incident take place. The 'Gold Control Team' was based at the trust headquarters (THQ) and includes the Chief Executive, Director of Nursing and Medical Director. The gold control team controls the trust response to the major incident and will liaise with external 'Strategic Control Gold' (SCG). A silver control team will be established on the affected site/ s.
- Senior staff told us that band six and seven nursing staff carried the bleep and had completed training on the major incident policy so that they would be aware of their role in such an event. We were told that the last major incident exercise took place in 2015. Staff told us that I5 was the designated receiving ward for trauma and orthopaedic patients and when necessary existing patients on I5 would be moved to other clinical areas so that beds could be freed up on I5.

Are surgery services effective?

Requires improvement

We judged the effectiveness of the surgical service as requiring improvement.

- Outliers were located throughout the surgical service. This relates to patients who were situated away from the speciality they should have been admitted to. Concerns were also identified that patients placed on general surgical wards or outliers were not reviewed daily. We were told that in response to this the surgical division was currently undergoing a review of seasonal capacity and demand to ensure bed base was the right size within the clinical areas.
- Not all staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.
- On ward I5, we reviewed six patients do not attempt cardiopulmonary resuscitation (DNACPR) documents and supporting documentation. Four patients DNACPR documents had not had a mental capacity assessment completed and review dates for DNACPR assessments not identified. We raised this with the nurse in charge and later with the surgical matron responsible for this clinical area who took action immediately.
- The 'Core Standards for Pain Management, Faculty of Pain Medicine' were reviewed for compliance by the trust on the 18 February 2016. Information provided by the trust did not identify the action plan or monitoring arrangements in place in response to the shortfalls identified.
- Senior staff told us that a new governance structure was recently implemented trust wide. This meant that learning and monitoring processes from audits were not as robust as they should have been.

- The trust were unable to confirm whether NMGH surgical services met the 'NHS England seven day services priority standards around 'Time to first Consultant review.
- Staff said that patient's meal times were not always protected.
- We noted some shortfalls in nursing appraisal processes in theatre areas and on the surgical wards. Appraisal data for the theatres and surgical wards for 2015 showed that 45 to 100% of nursing staff had an appraisal.
- Three medical staff identified concerns relating to very little supervision and difficulties experienced completing work-based assessment.

However we also found:

- The service provided evidenced based care as identified within evidenced based clinical guidelines. Monitoring of clinical guidelines had taken place.
- Care was provided in line with NICE CG50.
- Patient's surgical outcomes were monitored and reviewed through formal national and local audit. Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for people.
- Patients received care and treatment by trained, competent staff who worked effectively within the multi-disciplinary team.
- Mental health awareness training sessions had recently been introduced for staff to attend.
- Corporate and local induction processes were in place for new staff.
- Consent was obtained from patients prior to procedures.
- A new pain tool for patients with cognitive impairment was being rolled out across the trust.
- We saw evidence that good multi-disciplinary team working took place.

Evidence-based care and treatment

- Senior staff said a new governance structure was recently implemented trust wide, which meant that learning and monitoring processes from audits were not as robust as they should have been.
- Senior staff told us a new clinical audit strategy had just been approved and currently surgical specialities were involved in their own audit programmes. Staff from the orthopaedic theatres said regular theatre audits took place, which included monthly peer audits for quality assurance purposes and snap shot audits.
- The trust participated in 21 national audits from 2013 to 2015.
- The surgical national audit plan for 2014 to 2016 identified audits the surgical department had participated in. The 2016 audit data provided was at data collection stage.
- In 2015, North Manchester General Hospital (NMGH) audit schedules included, the National Emergency Laparotomy Audit – Year 2 (December 2015) and the National Prostate Cancer Audit.
- The National Prostate Cancer report was received by the trust in November 2015; the directorate action plan was in development.
- The National Emergency Laparotomy Audit comparison report for December 2015 flagged the collection of data at amber status. Amber status = 50% to 70% of the estimated caseload entered.
- The pain team confirmed audit schedules for acute and chronic pain were in place. Targeted pain audits took place, for example, patient controlled analgesia and epidural disconnects which captured information on missed doses of medication.
- The trust surgical governance team confirmed the number of out of date surgical policies as nine. Evidence provided showed the trust had taken action to ensure these policies were either reviewed, updated or to be discussed at the next patient safety committee meeting.
- The policy status report, 'Document Management Status Report - Divisional Summary for Anaesthesia & Surgery' (25 February 2016) identified some movement in the status of individual documents since the existence of the new division. At the end of June 2015, nearly one in five (18%) of the division's live policies and guidelines had reached or exceeded their expiry date. A steady improvement was seen and this figure had reduced to one in seven (13%) being at or passed their expiry date. The actions identified the division would continue to prioritise documents for review to ensure they were fit for purpose; stock checks' were underway to identify documents no longer required and those that could be merged together as part of their review.
- Guidance from authorities such as the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed

ten evidenced based guidelines, which were in date, for example, the Prevention of VTE (venothromboembolism) Policy (V3) was based on NICE clinical guidance 92.

- Nursing staff told us that policies and procedures reflected national guidance and could be accessed on the trust intranet site. We saw that local policies, such as falls prevention policies and risk assessments were written in line with national guidelines.
- Nutritional evidenced based and best practice based guidelines were available. We reviewed five guidelines, which were all in date. Nutrition was discussed at the trust quarterly nutrition steering group attended by members of the multi-disciplinary team and the artificial nutrition steering group, which included attendance, by community staff, medical and nursing staff.
- Evidence-based standards, which build on the World Health Organisation Surgical Safety Checklist approach, were developed and tested by clinical experts. The standards, named 'National Safety Standards for Invasive Procedures (NatSSIPs)' were formally endorsed by a number of organisations. Senior staff told us that guidance, which related to invasive procedures and standards, was in implementation stage at the trust. Since September 2015, two multi-disciplinary meetings had taken place, which involved the medical governance lead, an anaesthetist and urologist. A project plan was formulated and activated in November 2015 to implement the 'Safety Standards for Invasive Procedures' within the trust.
- The trust 'World Health Organisation' (WHO) compliance audit data from January 2015 to December 2015 identified NMGH compliance in relation to completion of the WHO checklist. WHO checklist (surgical safety checklist) completion was from 94% to 99%. The average score for sessions with a WHO briefing was 97%.
- Pre-operative investigations and assessments were carried out in accordance with NICE clinical guidelines.
- Care was provided in line with NICE CG50. This guideline identified measures staff took to recognise and respond to deterioration in patients' conditions. We saw that staff monitored the patient's progress throughout the patient journey from the pre-assessment stage through to the post-operative stage. Baseline physiological observations such as respiratory rate, heart rate and temperature were taken during the pre-assessment process followed by agreed frequencies of physiological observations at the patient's admission through to their discharge home. All wards used an 'early warning score' to detect deteriorating patients and escalated deteriorating patients through the identified escalation framework.

Pain relief

- Two anaesthetists and a lead nurse who are contactable lead the adult pain management team by bleep for advice on pain management issues. The core pain service was provided between 8am to 5pm. The team comprised of a lead nurse, 6.43 wte band seven nurses and 4wte band six nurses. This team of nurses cover the four hospital sites. Two of the nursing staff have completed the 'PETALS' course, a pain management training course.
- In addition to the pain team, anaesthetists and surgeons provide advice on pain management. An on call anaesthetist provided pain management support during the out of hour's period.
- Designated anaesthetist staff manage pain services. Initial requests for out of hours management were received by the anaesthetist on call for emergencies. We were told that this individual may or may not have intermediate pain training and that the consultant on call for emergency anaesthesia provided expert advice when needed.
- Pain link nurses were located in the clinical areas at North Manchester General Hospital. The pain link nurses met monthly and meetings were pre-planned for the year.
- A pain service information folder, was updated monthly, was available at each hospital site. Pain policies and procedures, which are based on NICE guidance, are in place.
- The 'Core Standards for Pain Management, Faculty of Pain Medicine' were reviewed for compliance by the trust on the 18 February 2016. The outcome showed that pain management services were not fully compliant against the core standards. In areas of none or partial compliance actions were identified to mitigate these shortfalls, for example, work was in progress to arrange multidisciplinary team meetings. Information provided by the trust did not identify the action plan or monitoring arrangements in place in response to the shortfalls.

- We tracked seven patients' pathways, who were admitted for surgery; part of the pathway related to pain management. We observed pain management discussions took place with the patient prior to and post-surgery. We saw that a pre-operative assessment for post-operative pain relief had taken place and was documented. One patient said they had experienced no pain following their procedure and said they had received sufficient pain medication to ensure they remained pain free. Pain assessment tools were completed in those patient records we reviewed.
- Staff said that pain tools were used to determine patents pain levels. For people who had learning disabilities or dementia staff said they would observe non-verbal signs to determine levels of pain. Discussions with the trust pain team identified that a new pain tool for patients with cognitive impairment was being rolled out across the trust. We saw a copy of this pain tool, which was to be used to assess those patients who had communication difficulties, such as patients living with dementia, stroke, learning disability and acute confusion.

Nutrition and hydration

- Dietetic support was provided by the dietetic team, which was led by two (1.77wte) dieticians. They are supported by one band six dietician who works with diabetic patients in outpatients at NMGH, two band five dieticians and administration support. In addition, nutrition link nurses were based at ward level.
- New patient referrals were received by the dietetic team through an online referral system. Dieticians were allocated to ward areas; two band five dieticians undertook weekly outpatient clinics at NMGH where they saw patient referrals from consultant staff. The patient referrals included patients being advised in areas such as weight management. Where necessary these dieticians also refer patients to community health networks for continuing support.
- Systems were in place for hospital dieticians to refer direct to community dieticians following a quality improvement project in 2015.
- Patients admitted to hospital were screened within six hours of admission using the 'Malnutrition Universal Screening Tool' (MUST). Staff told us that there had been issues in ensuring that the MUST tool was completed fully. To address this a decision to incorporate the MUST tool into staff mandatory training sessions was taken. The MUST tool had been refashioned and relaunched in the last month and a pilot scheme, which used an electronic MUST tool, was being considered for use on the Oldham Hospital site. We reviewed nine patients' MUST assessments and saw that weekly rescreening of MUST status had taken place.
- A variety of food choices was available to patients. Special diets, for example diabetic, gluten free, renal, textured and allergy diets were available.
- For mothers breast-feeding their baby, breast-feeding facilities were available.
- Two patients from different clinical areas said that fluids were available; one patient said their water jug had been changed every two hours, whilst the other patient said they had regularly been offered fluids.
- On ward F5, one patient commented that the food was 'ok' but could be warmer.
- Patients, carers and staff could access a café, restaurant and vending machines.
- Staff told us that 'protected mealtimes' had been introduced; however, the patient's mealtime had not always been protected due to ongoing workloads.
- Staff told us that were a patient's MUST score was identified as two or above, this meant the patient was identified by a red tray. This tray served as an indicator of patient risk and informed staff that assistance may be required with meals.

Patient outcomes

- The trust's hospital episode statistic (HES) for July 2014 to June 2015 showed that 20,600 patients were admitted for surgery at North Manchester General Hospital (NMGH).
- No theatres at the trust were used at more than 90% utilisation. (Pennine Acute Hospitals NHS Trust pre-inspection document, January 2016)
- We requested information relating to NMGH's participation in the Anaesthesia Clinical Services Accreditation Scheme (ACSA), including accreditation level, to-date, this information had not been provided by the trust.
- The Hip Fracture Audit 2014 / 15 showed that NMGH performed better than the England average for four indicators and worse for five indicators. (Pennine Acute Hospitals NHS Trust pre-inspection document, January 2016) An action plan was in place following the 2014 audit which identified five actions and their status for NMGH and Royal Oldham Hospital. Three actions were

completed and two actions for NMGH were identified as not achievable. We were not given any further information confirming whether all actions against this action plan had now been achieved. An action plan for the 2014 / 15 Hip Fracture Audit was not provided by the trust.

- The emergency department had been unable to implement the neck of femur fracture pathway for patients with this condition effectively because of the shortage of beds.
- Staff told us of a recent audit, which identified 67% of patients with fractured hips, had delayed surgery due to the lack of a surgeon or beds. We were told of two recent examples of patients whose treatment was delayed. We discussed the concerns raised about delayed surgery for patients who had a fractured neck of femur with two consultants and we were told an action plan had been created with potential solutions. One solution included the creation of dedicated daily fractured neck of femur trauma theatre lists or cancelling elective patients. Talks with managers were ongoing about how to resolve delayed surgery.
- The National Laparotomy Audit (2015) showed that NMGH had a mixed result with three out of 11 indicators achieving 70 – 100%. (Pennine Acute Hospitals NHS Trust pre-inspection document, January 2016).
- We were told that outliers were located throughout the service. Outliers relate to patients who were situated away from the speciality they should have been admitted to. For example, general surgical patients placed on the male urology ward. Staff identified concerns that patients placed on general surgical wards or outliers were not reviewed daily.
- Information on patient outliers was provided following inspection by the trust. Statistics from August 2015 to January 2016 showed between 21 to 38 outliers identified within the surgical service. We were told that the surgical division was currently undergoing a review of seasonal capacity and demand to ensure bed base was the right size within the clinical areas.
- On inspection, we visited three surgical wards and spoke with staff specifically about their experience of patient outliers placed on their wards. These wards were, I5, F3 and F5.
- On the 25 February 2016, ward I5 (trauma and orthopaedics) staff told us that three of their patients were on other wards. They identified that ward I5 could accommodate from 15 to 16 outliers (preoperative or post-operative patients) at any one time. Staff said that patients identified as outliers were not reported as a clinical incident and no specific outlier policy was available to refer to for guidance.
- On the 25 February 2016 ward F5 staff identified they had eight outliers on the ward and they had to move surgical patients to the short stay ward to make room for electives.
- On the 26 February 2016, staff from ward F3 (male urology) confirmed 11 outliers on the ward and that five urology patients were placed on other surgical wards. Staff from ward F3 said that two urology patients were taken of the ward each night and placed on other wards; for example, placement was on surgical wards C3, C4, D5 and D6. Staff said they were contacted nightly by the night manager or bed management team at 8.30pm and asked to give two patients names that could be moved to another ward. These patients were then moved at midnight to a new ward.
- Generally, medical patients were admitted onto F3; the longest stay medical patient had been on the ward since January 2016. Staff from F3 said that staff morale was affected due to the high presence of outliers. This was because staff wanted to care for urology patients.
- Movement of the urology patients from F3 had caused difficulties when patients were discharged home. This was because patients may be discharged home without the relevant community support, equipment or correct supplies to support their needs. Staff said that to-date this was not known to have affected the patients care.
- Movement of urology patients meant some urology patients had frequent moves between wards. For longer stay patients who were moved from F3 to the five-day wards C3 or C4, these patients were moved back to F3 at the weekends due to the closure of wards C3 and C4. These patient moves were discussed with senior management who identified that movement of these patients were because of the winter pressures plan.
- The Health and Social Care Information Centre (HSCIC) data from April 2014 to March 2015 for the surgical service identified that patient reported outcome measures (PROM) data were improving or similar to the England average for all measures apart from varicose vein outcome measures. These measures indicate the percentage of patients who had improved for each procedure and scoring mechanism.
- The relative risk of emergency readmission for elective admissions in the top three specialities, urology, trauma

and orthopaedics and colorectal surgery confirmed that two specialities urology (106), trauma and orthopaedics (121) readmission rates were higher than the England average of 100. We observed that the data confirmed that colorectal surgery readmissions were below the England average of 100. A score below 100 indicates a positive finding, whilst a score above 100 represents the opposite. (Hospital Episode Statistics (HES) (June 2014 – May 2015)

- The relative risk of emergency readmission for non-elective admissions in the top three specialities, general surgery (109), trauma and orthopaedics (130) and urology (108) confirmed that all these specialities emergency readmission rates were higher than the England average of 100. A score below 100 indicates a positive finding, whilst a score above 100 represents the opposite. (HES (June 2014 – May 2015)
- Patient-Led Assessments of the Care Environment' (PLACE) assessments provide a snapshot of how an organisation was performing against a range of non-clinical activities which impact on the patient experience of care. These included, cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance of healthcare premises and dementia friendly environment (whether the premises are equipped to meet the needs of dementia sufferers against a specified range of criteria). The PLACE assessments at NMGH took place from the 14 May to 29 May 2015. The outcome of this assessment showed that the trust was rated higher than the national average on cleanliness, privacy, dignity and well being, condition, appearance and maintenance and dementia friendly environment. However food and hydration scored lower (87.84%) than the national average of 88.49%, which was a fall of 1.01% compared to 2014. Separate figures for North Manchester General Hospital (NMGH) were not available. Following this assessment, actions and recommendations were identified. One action, which related to NMGH, included a review of outdoor signage and the removal of pre-merger signs. The action timescales to be achieved within the financial year, March 2016.

Competent staff

- Staff told us staff could approach link trainers for advice and support in areas such as pregnancy testing, tissue viability, diabetes and resuscitation.
- Appraisal data provided by the trust confirmed 100% of nursing staff in the Pre Op Assessment unit had appraisals from April to November 2015.
- Appraisal data for the theatres (north) at NMGH showed shortfalls in appraisal completion from April 2014 to November 2015. From April 2014 to March 2015, we saw that 44.6% of nursing staff had an appraisal. This figure reduced to 29% from April to November 2015.
- Appraisal data for the remaining surgical wards from April to November 2015 showed that 50 – 100% of nursing staff had an appraisal during this time. Staff told us that the appraisal process was useful and that an annual appraisal process was in place.
- The 'Medical Revalidation & Appraisal Quarterly Report' for November 2015 confirmed that the appraisal cycle for 2015/16 ended on 28th February 2016. Appraisal statistics for medical and dental staff for April 2014 to March 2015 confirmed that 100% of consultants had an appraisal. For the year, April 2014 to March 2015 40% of medical and dental staff had an appraisal.
- Medical staff told us they received three to four hours protected teaching time weekly.
- The trust identified there was no specific critical care training in place for recovery staff. Instead, staff completed in-house training competencies, could access modules for recovery, and advanced recovery at a local university. Some staff had transferred to recovery from the intensive care unit, which meant they had level three transferable skills in critical care.
- Senior staff confirmed that staff had completed training programmes in areas such as anaesthetics, recovery practitioner and scrubs practitioner during their first six months working on the unit or in theatres.
- The trust identified 44 staff worked within the theatre recovery areas at NMGH. Of these 25 staff had completed training in the anaesthetic/recovery module, Anaesthetic Nursing (ENB 182). Three nurses were currently undertaking the anaesthetic module, which was due for completion in September 2016. Recovery staff had also undertaken training in intravenous drug administration, extubation and 12 lead electrocardiograms (ECG).
- Mental health awareness training had recently been introduced for staff and a further training session was planned for March 2016. Training statistics for 2015 to 2016 identified 19% of nursing and midwifery staff and 4% of medical and dental staff had accessed mental health awareness training sessions.

- All middle grade and junior doctors had allocated clinical and educational supervisors. In relation to general trainee supervision to develop skills, 100% of junior and middle grades were supervised by a consultant.
- Three junior medical staff said they had received very little supervision saying 'Left to get on with it' and that it was difficult to complete their work-based assessments.
- Staff told us that formalised clinical supervision was not available; however, an open door policy existed for staff to discuss issues as part of the supervision process. A six-month preceptorship package was in place for new starters in which time staff completed preceptorship packs. We observed a completed preceptorship pack completed by a recovery nurse.
- Staff told us they completed core and service specific training sessions. A junior staff member had just completed the observation course which included information on how to use the early warning score system and how to use tympanic temperature probes. This person said they had an allocated mentor and six months to complete the documentation linked to this course.
- Staff told us corporate and local induction processes were in place for new staff. One staff member told us that as part of their induction they were supernummary for six months. During this supernummary period, they observed practice and were observed performing tasks by a buddy, they paired up with. After six months this person had a development meeting to discuss their training needs and progress and at one year had an appraisal which they described as 'really useful.'

Multidisciplinary working

- Eight patients records identified their care was reviewed daily by senior clinicians at the daily ward round.
- Seven patients records showed that the multi-disciplinary team (MDT) were involved in patients care and treatment plans.
- Three staff said that the surgical treatment centre did not provide a medical handover sheet when patients were transferred onto the ward.
- Orthopaedic multi-disciplinary team (MDT) meetings took place alternate Fridays. These meetings were minuted and action plans generated by one of the orthopaedic consultants.
- Staff from the orthopaedic team described good team working existed within the MDT.
- Staff told us that daily ''safety huddle' MDT meetings took place with members of the multi-disciplinary team present where issues such as incidents and safeguarding issues were discussed. We observed the daily safety huddle meetings on ward I5 that were attended by the physiotherapist, occupational therapist, nurse and discharge nurse. The meeting included holistic discussions about patient's progress and the care they required. We observed effective interaction between the team, staff compassion and understanding was exhibited during discussions about individual patients.
- We observed that holistic discussions took place when planning patients care.
- Doctors and nursing staff told us they worked well together within surgical specialities.
- Dieticians attended multi-disciplinary meetings in a number of specialities, for example, head and neck and diabetic specialities.
- Ward link nurses worked closely with the end of life care team and chaplaincy to ensure that patients at end of life received the necessary support and care they required. The ward link nurse acts as a resource regarding end of life care to other staff on the ward.
- Senior medical staff said they had seen an improvement in cancer multi-disciplinary team meetings in that attendance and the chair's role at these meetings had improved.
- Colorectal surgical multi-disciplinary staff groups met bimonthly at formalised audit meetings to discuss patient cases.

Seven-day services

- We asked the trust whether North Manchester General Hospital's surgical services met the 'NHS England seven day services priority standards around 'Time to first Consultant review and were told that the division was in discussion.
- Surgery, which took place out of hours, was supported by a dedicated surgical team, which consisted of seven consultants for each hospital site. Full theatre lists were available including trauma lists. When patients had identified vascular treatment needs, they were transferred to Oldham Hospital.
- Theatres, including anaesthetics and recovery had staff on duty out of hours to cover emergencies.

- Physiotherapy services were provided Monday to Friday with an on-call service at weekends for priority patients.
- Staff confirmed effective multi-disciplinary team (MDT) working throughout the service and with external stakeholders. Doctors, pharmacy support and radiographers were easily accessed out of hours.
- Patient investigation results could be accessed easily, for example, the online patient x-ray (PACs) system provided staff with details of the patients x-rays pre-operatively.
- Staff told us that staffing levels were sufficiently maintained until the unit closed at 8pm Monday to Friday.
- During out of hour's periods, after 5pm and at weekends, dietetic staff said that staff could access emergency nasogastric feed regimes until dietetic staff returned to work.

Access to information

- Staff gave examples of how information was shared amongst the MDT. For example, where patients required nutritional support in the community the dietician wrote to the patients GP to request that the GP referred their patient to the relevant community team.
- District nursing staff received a patient's initial referral via secure fax. Systems were in place for hospital dieticians to refer direct to community dieticians following a quality improvement project in 2015.
- The patients GP received information about their procedure and treatment via a written paper record, which the patient gave them. GPs also accessed patient information through the patient's online healthcare record.
- The patient's doctor who arranged for the referral to be sent to the relevant allied healthcare professional initiated the patient's occupational health and physiotherapy referrals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff identified different consent forms were used to obtain patient consent. The consent forms used were dependent on the following factors: the type of procedure, the patient's ability to consent, for example, patients with dementia type conditions or learning disabilities and for patients whose consciousness was not impaired.
- Discussions with one post-operative patient confirmed they were informed of what to expect following surgery and during the preoperative period had signed a consent form.
- Staff said patients with dementia type conditions were generally supported through the consent process by their relatives.
- We saw that consent forms had been completed and signed in eight patient records.
- We asked five staff about their understanding of the Mental Capacity Act and deprivation of liberty guidance. One staff member was aware of what this guidance involved. Two staff were unable to explain what this guidance involved, whilst another two staff said they had not completed Mental Capacity Act or Deprivation of Liberty training. Despite this observation, we found that for the majority consent was taken appropriately.
- At inspection, we reviewed documentation for some of those patients who were identified as requiring assessment and completion of 'do not attempt cardiopulmonary resuscitation (DNACPR)' documentation and mental capacity assessments.
- On ward I5, we reviewed six patients DNACPR documents and supporting documentation. We saw that four patients DNACPR documents had not had a mental capacity assessment completed and review dates for DNACPR assessments not identified. We raised this with the nurse in charge and later with the surgical matron responsible for this clinical area who took immediate action to review all the patients and their documentation.
- On ward F5, we reviewed three recently reviewed DNACPR documents, which were fully completed.
- We reviewed a patient's deprivation of liberty and mental capacity assessment on another clinical area and found the assessments were completed and reviews of the patient's deprivation of liberty status had taken place. However, we asked to see the most recent deprivation of liberty review outcome document and were told by the nurse in charge they were waiting for the latest document to be posted to the hospital from the safeguarding team. We asked whether this was normal practice and were told that it was.

Are surgery services caring?

Surgery

Good

We judged caring as good as the service provided caring services to the local population.

- Patients received compassionate care with good emotional support.
- Patients were fully informed and involved in decisions relating to their treatment and care.
- Support was provided by the multi-disciplinary team during the patient's admission, stay and in preparation for their discharge home.
- Patient's emotional needs were supported throughout their surgical experience.

Compassionate care

- We spoke with six patients and four patient's relatives who told us they were generally happy with the care and support received. However, two patients from ward I5 identified some concerns about the night staff and medication being given late and described some staff as 'prickly'.
- Throughout our inspection, we observed members of medical and nursing staff provided compassionate and sensitive care that met the needs of patients. Staff had a positive and friendly approach and explained what they were doing, for example when completing the patient's clinical observations. On F5 we observed staff respond to patients compassionately, asking how patients felt and gave reassurances when needed.
- On I5, we observed staff immediately responded to patients requests and also checked with other patients whether they required any assistance, for example, did the patient want a drink.
- On ward I5, we observed that a physiotherapy assistant was caring and ensured the patients privacy by asking to assist with the patient's gown.
- On F5, we observed patients were respected and their dignity maintained. Curtains were pulled around beds when required and patients and relatives were taken to a private area for discussions.
- On the admission unit, we observed one patient's intravenous cannula being flushed without the curtains being closed.
- The action plan from the 2014 patient survey identified actions in response to patient concerns, which related to staff attitude and staffing levels.
- Feedback cards and comment boxes were available throughout the service. We saw patients had given positive feedback about their experiences on the cards displayed in ward areas.

Understanding and involvement of patients and those close to them

- We saw that patients and their families were involved in discussions about their care and treatment documented in eight patients' records. Two patients told us that staff were very informative and had given full explanations of the issues under discussion.
- We observed a patient discharge and saw that everything was explained clearly and advice given should the patient experience problems. Information of who to contact out of hours was given should the patient experience problems.
- Patients told us that they had discussions about their procedure during the pre- admission clinic. Post-operative verbal and written information was provided by the nursing and medical staff about their procedure and what to expect.
- On ward I5, we observed a staff telephone discussion with a patient's relative and heard the nurse give clear information in a sensitive manner.
- Patients living with dementia were given the 'This is me' document prior to admission prior to admission so that the document could be completed in their own home. The document contained information about the patient, which the patient and family completed.
- Patients with learning disabilities were given a 'traffic light document', which is completed by the patient and family prior to admission to hospital. This document included a mixture of pictorial and written information. The reader was informed of important information about the patient including any reasonable adjustments they may need to ensure they received the best care, given in the right way for the patient.

Emotional support

- One relative of a patient identified concerns about the care received on F5. They said the buzzer was left out of reach making it difficult to summon staff for assistance

and that staff were unsupportive and communication not effective. We escalated this relative's concern to the palliative care team who were due to meet with the family.
- In theatres, we observed theatre staff welcomed patients into the anaesthetic room, put patients at ease and answered patient's questions.
- Staff showed a good awareness of patient's with complex needs and / or those patients with a learning disability. Staff told us during the initial pre- assessment staff determined what immediate support the patient required to aid them in their hospital admission and subsequent discharge.
- Staff from ward D6 identified that due to the acuity of their patient group they were often too busy to provide sufficient one to one emotional support to patients.
- A specialist stoma nurse covered the North Manchester General Hospital and Oldham Hospital sites. This nurse visited patients on the wards, supporting both the patient and family. The patient and family were referred to the stoma nurse pre-operatively for counselling sessions where needed; these sessions continued for up to one year following surgery.

Are surgery services responsive?

Good

We judged responsive as good as the service provided responsive services to the local population.

- The surgical service had good support from the surgical centres within the trust and from tertiary centres.
- Service planning and delivery considered the patients' needs, which meant changes to the service and how it was delivered, benefited the patient.
- The trust is involved in the 'Healthier Together' initiative, which looked at how patients would receive health and care in the future. Under 'Healthier Together' the hospital plans to drive up quality and safety, 'single services' would be formed within networks of linked hospitals working in partnership.
- There was good access and flow to services, which met patient's needs. Service developments had improved patient access to treatment. For example, an anaesthetic clinic had operated for the last five months whose remit was to review patients for suitability for day surgery.
- The 'hot clinic' was run by senior medical staff for patients with biliary colic. Hot clinics allow patients with abdominal pain not requiring admission to be sent home to re-attend the following day when they would have scans and be reviewed by the specialist registrar with the scan results to decide on any further management.
- The 18-week referral to treatment (RTT) – incomplete pathways performance data confirmed the trust had achieved 95 – 96% compliance against the RTT standard of 92%.
- The incomplete RTT standard had been achieved for all specialities and had the eighth best national risk assessment score.
- The trust had implemented a dementia strategy in October 2015 and had appointed a dementia lead, to enhance the life and quality of care for people living with dementia.

However we also found:

- Staff identified concerns there was no radiographer presence after 5pm; after 5pm, an on call radiographer system was in place. However, staff did not identify that patient care was comprised because of this.The trust identified there was 24 hour on site presence of a radiographer.
- Staff identified concerns relating to frequent patient moves throughout the service and patient outcomes including care being affected.

Service planning and delivery to meet the needs of local people

- To ensure the changing needs of local people were met, 'Healthier Together' had been looking at how patients would receive health and care in the future. The 'Healthier Together' programme was a key part of the wider programme for health and social care reform across Greater Manchester and comprised of three parts: Primary Care (including GP services), Joined up Care and Hospital Care.
- Health and social care professionals clinically led the programme; its aim was to provide the best health and care for the people of Greater Manchester.

- Under 'Healthier Together' the hospital planned to drive up quality and safety, 'single services' would be formed within networks of linked hospitals working in partnership. This meant care would be provided by a team of medical staff working together across a number of hospital sites within the single service. The trust self-assessment document confirmed where they met the standards and identified proposals to achieve those standards either partially met or not met.
- As part of 'Healthy Futures', the Trust would have two specialist centres for emergency trauma and orthopaedic services based at North Manchester General Hospital and The Royal Oldham Hospital.
- Staff told us that an anaesthetic clinic had operated for the last five months whose remit was to review patients for suitability for day surgery.
- 'Hot clinics' were run by senior medical staff for patients with biliary colic. The hot clinics allowed patients with abdominal pain not requiring admission to be sent home to re-attend the following day when they would have scans and be reviewed by the specialist registrar with the scan results to decide on any further management.

Access and flow

- The trust agreed the 'Operational Policy, Elective Access - Booking and Scheduling Department' (version 1) guidance with local Clinical Commissioning Groups (CCGs). This was to ensure that guidance was available for the elective access booking and scheduling (B&S) team to manage patients' waiting for treatment on an elective pathway. It relates to patients requiring access to elective outpatient treatment, elective inpatient treatment and diagnostic tests.
- Weekly directorate patient list meetings took place, which included the directorate manager, waiting list co-ordinator and elective access booking team. Actions and current performance were discussed and held to account at the weekly high-level referral to treatment (RTT) performance meeting that involved directorate managers from surgery and elective access. Actions were recorded and issues escalated through the escalation process.
- Staff confirmed patients waiting times were managed through directorate meetings attended by the multi-disciplinary team. The trust monthly referral to treatment (RTT) meeting and weekly local RTT meetings looked at fill rates and at which campaigns are proceeding.
- Vascular clinics at NMGH were one-stop duplex scan clinics which meant patients were seen, had their duplex scan and were given results with a plan on the same day. This had reduced this particular pathway length by four weeks and would be monitored by an audit, which would commence in March 2016.
- Surgical admissions followed surgical pathways, which started at pre-admission clinics based at hospital sites following the patient's referral for treatment.
- Procedure specific pooled lists took place.
- Interventional radiology sessions for pain lists and urology lists took place until 5pm. Staff identified concerns there was no radiographer presence after 5pm; after 5pm, an on call radiographer system was in place, however, the trust identified there was 24 hour on site presence of a radiographer. However, staff did not identify that patient care was comprised because of this.
- The referral to treatment data (RTT) target was 92%. Staff said that RTT was managed by speciality, not by site, which meant that RTT information provided by the trust related to all sites the specialities were based on. Following the inspection we spoke with a senior staff member who provided additional information which confirmed 95 -96% compliance against the 18-week referral to treatment (RTT) – incomplete pathways performance target.
- Senior staff told us the trust did not currently collect data, which related to patient waiting times to see a consultant. We were told that this data collection topic was currently under review.
- The average length of stay at NMGH for the top three specialities identified by Hospital Episode Statistics (HES) data (July 2014 – June 2015) confirmed the average length of stay for elective urology and trauma and orthopaedics was lower than the England average. Oral surgery patients had a higher length of stay of 3.1 days against the England average of 2.2 days.
- The average length of stay at NMGH for the top three specialities identified by HES data (July 2014 – June 2015) confirmed that the average length of stay for non-elective general surgery, trauma and orthopaedics and urology was lower than the England average for each speciality.

- Staff identified concerns relating to frequent patient moves throughout the service and patient outcomes including care being affected.
- On occasion, day care patients were transferred from Rochdale Infirmary by a consultant-to-consultant referral process to a surgical ward at NMGH. Prior to a patient's arrival on a ward a period of assessment would have taken place on the surgical triage unit at NMGH.

Meeting people's individual needs

- Single sex accommodation was provided in clinical areas.
- The Ethnic Health Department provided verbal and written language interpretation services for over 82 languages spoken within the geographical area of the trust.
- The British sign language interpreting services were provided for patients with sensory difficulties, braille or large text documents were provided for visually impaired patients.
- Telephone interpretation services were provided for non-urgent standard consultations or appointments.
- A translation service was provided upon request.
- The learning disability service, which was part of the safeguarding team, worked in liaison with learning disability liaison nurses to ensure patients with a learning disability were supported when they visited hospitals within the trust.
- The trust had implemented a dementia strategy in October 2015 and had appointed a dementia lead, to enhance the life and quality of care for people living with dementia. We saw training statistics, which confirmed that some surgical staff had completed level one dementia training at NMGH. We noted shortfalls in nursing and medical attendance at this training identified from the trust training statistics across surgery. The trust identified training targets and headcounts for each staff group in each clinical area. A summary of staff attendance at dementia level one training was not provided by the trust to give an overall training status for this area.
- The service provided advice and training to hospital staff to enable them to provide the most appropriate care for patients with a learning disability. They also worked with staff to ensure reasonable adjustments were made for patients coming into or in hospital.
- Information was available to patients and carers to help them when they attended hospital as either an in-patient or outpatient. For example, 'Patients with a learning disability: Care within hospital - An information guide' (February 2015). The guide included a nursing and carer agreement in relation to the patients care requirements and who would be accountable for assisting them in these areas. A pictorial version of this document was also available for patients with a date of review March 2017).
- Staff told us they could access information about the patient in their 'This is me' document, which patients with dementia type conditions bought into hospital with them.
- Patients with learning disabilities completed a 'Traffic Light Assessment' tool, which identified information about their specific needs. Relatives and carers were involved and 'walked through the patient journey' with the patient prior to their admission so that they understood the process and could help the patient undertake this journey.

Learning from complaints and concerns

- The trust's 'Complaints Handling Policy (v7, ratified 26 November 2015)' included actions, which staff must take in line with the duty of candour (being open).
- Patients could access information about how to complain and direct their concerns and complaints either to the hospital complaints department or through the patient advice liaison service. For those patients with a learning disability information in an easy read pictorial format could be provided on 'How to Make a Complaint.' We saw that this information could be accessed in a number of languages and information, which advised this, was present.
- Staff confirmed that complaints were managed through the 'Patient Advice Liaison Service (PALS)' and complaints departments. Directorate managers, governance leads and the divisional director were made aware of any complaints and their subsequent outcomes. Recently a 'listening clinic' led by a matron was developed for patient complaints.
- Staff said that patients were invited to discuss their complaint and were involved in determining the lessons learnt from such complaints and / or incidents.

Are surgery services well-led?

Surgery

Requires improvement

Overall, we rated the leadership of surgical services at North Manchester General Hospital to be requires improvement.

- Formal surgical service strategies were not in place.
- The service had only recently implemented governance, risk and quality measurement processes were in place, which meant that learning and monitoring processes from governance and quality measurement processes were not fully embedded .
- Staff identified concerns about the management of outliers throughout the service. These concerns included frequent patient moves, patients not reviewed daily on general surgical wards and patient outcomes including care being affected by these moves.
- Some of the staff we spoke with identified that their knowledge of the trust core values and what they involved was limited.·

However we also found:

- Staff received updates through the governance, risk and quality frameworks. A risk register was in place, which identified areas of risk across the service.
- Nursing metrics were implemented in February 2016 to monitor clinical performance in specified areas.
- New appointments were made within the leadership of the risk and governance areas.
- Clearly defined management and clinical leadership structures were now in place.
- Individual management of the different areas within the surgical service were well led.
- Public and staff engagement processes captured feedback from both groups, which was generally positive.

Vision and strategy for this service

- In 2015, the trust captured staff feedback through 'Pride in Pennine' online workshop processes. The trust identified that staff shared nearly 27,000 ideas, comments and votes to co-create the trust vision, values and goals. The values were jointly agreed and were Quality-driven, Responsible and Compassionate. We asked staff what their involvement was in developing the core values and were told by one staff member that they had not been involved in the development of the core values. However, they said that staff had been invited to participate in the development of the core values, which included posting views on the trust intranet.
- We asked staff what the trust core values were and four out of five staff were able to name them.
- The trust had developed an overarching transformational map (2015 / 2016) which identified 'Quality as our first priority.' Two staff were aware of this vision and plan. The trust identified ten corporate priorities for 2015 – 2016, which included driving up quality and performance and progression toward foundation trust status.
- he surgical service did not have a formalised strategy in place; however, we were told that the surgical service was developing plans in line with 'Healthier Together.' The 'Healthier Together' programme was a key part of the wider programme for health and social care reform across Greater Manchester and comprised of three parts: Primary Care (including GP services, joined up care and Hospital Care. Health and social care professionals clinically led the programme and its aim was to provide the best health and care for the people of Greater Manchester. Under 'Healthier Together' the hospital planned to drive up quality and safety, 'single services' would be formed within networks of linked hospitals working in partnership. This meant care would be provided by a team of medical staff who would work together across a number of hospital sites within the single service. The trust self-assessment document confirmed where they met the standards and identified proposals to achieve those standards either partially met or not met.

Governance, risk management and quality measurement

- The chief executive officer confirmed new directorate triumvirate structures were put in place from May 2015. These structures included new clinical directors and clinical governance divisional support. We met with the new surgical clinical governance team who confirmed that since this staff reorganisation they had been redefining the surgical directorate's governance system to enable it to be fit for purpose for the current service.

- A new risk manager commenced two weeks ago and a service risk improvement plan was now in place. The service had a risk register, which identified risks across the service.
- Following a review of the governance system and membership, a governance lead and the medical director led the governance framework. We were told there had initially been limited consultant involvement due to consultant vacancies and limited consultant involvement in the governance system. Governance involvement were now reflected in the job plans of consultant staff. In December 2015 an internal audit, which had input from an external observer took place to ascertain the effectiveness of governance meetings. Following this audit there was increased engagement from clinical staff and action plans were produced. Senior medical staff said they had seen an improvement in audit and governance processes.
- Staff identified concerns about the management of outliers throughout the service. These concerns included frequent patient moves, patients not reviewed daily on general surgical wards and patient outcomes including care being affected by these moves. We were told that in response to this the surgical division was currently undergoing a review of seasonal capacity and demand to ensure bed base was the right size within the clinical areas.
- In February 2015, nursing metrics were rolled out. The metrics include measurements on pain, pressure ulcers, falls with harms and new venous thrombus embolisms. Pressure ulcers remain one of the divisions major care problems throughout the service. In response, the surgical division is working closely with the tissue viability and corporate nursing team to reduce pressure ulcer incidence.
- A safety programme across all hospital sites was implemented by the patient safety team to focus on incidents and complaints. Patient safety walk rounds were introduced and in May and June 2015, the patient safety team visited theatres. We saw the findings and an action plan displayed in the orthopaedic theatres following the infection control walk round.
- Safety issues were highlighted to staff groups through weekly 'Spotlight on Safety' newsletters from the chief executive officer and the quarterly 'Pride in Safety' newsletters. The winter 'Pride in Safety' newsletter identified its aim was to share learning across the organisation. One topic included the role of the safety improvement programme whose aim was to improve safety in eight areas, one of which was safer surgery.
- Quarterly 'Learning from experience' reports fed into divisional meetings.
- Each nurse in charge of ward and theatre areas completed a weekly ward safety huddle document. Information provided on this document included, the top five risks, top five categories of incidents, serious untoward incidents for the previous week, training compliance, friends and family test and compliments and complaints data.

Leadership of service

- A leadership structure was in place, which comprised of a lead divisional director, divisional medical director and divisional nurse director. A directorate triumvirate, service managers and clinical management teams reported to the director of operations. Staff said that senior managers including the divisional manager were supportive. The divisional manager was described as 'hands on and very aware of what was going on.'
- Senior staff described very little leadership support a year ago; however, this had changed since the introduction of the triumvirate. Now they received good support through the triumvirate, a vision was in place for service development, and an improvement programme was in place.
- The surgical nursing hierarchy included band 8a unit manager and band seven sister roles, who were supported by band six nursing staff. The unit manager reported to a senior manager.
- Communications took place between band seven and the band eight managers.
- Staff identified developmental opportunities; one staff member said they had been supported to complete their nursing degree and they were about to embark on the ward managers module course. Other band seven staff identified they had been recommended to attend the NHS Leadership course.
- A new 'Transforming Leaders' course was open to all senior managers and clinical directors.
- Staff identified some concerns about the lack of senior support for the dietetic service as the previous manager left in January 2016.

- Surgical ward manager meeting dates were planned from October 2015 to December 2016. These are forums were ward managers can meet together, discuss issues, and learn from each other's practice.

Culture within the service

- Staff told us that staff at all levels were supportive, approachable and friendly.
- Staff from orthopaedic theatres described staff morale as high; this was reinforced by comments from two staff who said 'Best run theatre I've worked in' and 'Consider ourselves as a family.'
- Staff told us of a good team working culture where staff helped each other.

Public and staff engagement

- Staff said that the CEO sent staff weekly Monday messages by email. We saw the Monday message dated 22 February 2016, which contained a range of information, for example, the new patient advice liaison service was now located 'front of house.' Additional information included the Care Quality Commission visit and a spotlight on safety section.
- Staff received monthly editions of 'Team Talk.' This was a magazine produced by the executive team to inform staff of the latest news.
- Staff said they had received good support and regular communications from their line manager.
- Staff confirmed that monthly team meetings took place and they could add areas for discussion to the agenda prior to the meeting. Team meeting minutes from ward I5 dated 28 January 2016 identified discussions had taken place in areas such as staff being mindful of how their actions and body language were interpreted, medication management reminders, completion of the safe staffing and safety huddle per shift and completion.
- The NHS Staff Survey 2015 identified that (Q21d) 57% (average for acute trusts was 70%) of staff would recommend the trust to family and friends if they required care or treatment and (Q21c).
- A score of 49% (average for acute trusts was 61%) by staff identified they would recommend the Trust as a good place to work. These figures showed an increase of between one (Q21c) to three (Q21d) per cent from the 2014 staff survey.
- In response to the NHS Staff Survey findings and Picker Institute's report into the staff survey, the findings were discussed by members of the senior management team (SMT) in February 2016. The SMT were asked to support the development of further actions to drive an improvement over the next six months before the start of the 2016 survey in September 2016.
- One member of staff told us they had given online feedback in response to a survey asking staff how happy they were.
- To obtain patient feedback we observed that ward I5 had a comments box attached to the wall on entry to the ward with a 'Your feedback matters' poster, information and contact telephone numbers for the patient advice and liaison service.
- Staff identified that patients were invited to the trust annual general meeting, involved in PLACE visits and were invited to a series of 'Listening into Action' focus groups throughout the year.

Innovation, improvement and sustainability

- Orthopaedic theatres staff said different coloured theatre lists were implemented as an indicator for when theatre lists changed so staff knew a new theatre list had started and the patient order on the list had changed.
- The Trust had launched a smartphone app called 'SmartGP (Pennine Acute)', aimed at GPs and users in primary care to assist in identifying services provided by The Pennine Acute Hospitals NHS Trust and to provide contact information to access those services. Navigation in the app was easy, intuitive and there were a number of useful tools such as a training log, reminder utility and an expenses log. There was also a 'feedback' area to report incorrect numbers or to provide suggestions on how the software could be improved. GPs who used their smartphone would be able to access information on the Trust from wherever they had an active cellular or Wi-Fi signal and it's been identified that it would be a useful reference when reviewing a patient's care, whether in the surgery or at the patient's home.

Critical care

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

Information about the service

The North Manchester General Hospital (NMGH) provides critical care services in a twelve bedded unit to both level 2 HDU and level 3 ICU patients. There is an ability to flex the occupancy up to a maximum of seven level 3 patients. The unit is run by intensivist/anaesthetists and has a designated clinical lead for both nursing and medicine.

The unit has two side rooms for the purpose of isolating patients that present an increased infection control risk. A critical care outreach service is also provided.

The unit only became a closed unit in December 2015, when the previous level 2 or HDU area combined with the level 3 facility. Up until that time the units submitted data separately to the intensive care national audit and research centre (ICNARC). According to the most recently validated and published ICNARC for 2015, annually the former level 3 unit had approximately 250 admissions and the former level 2 unit had approximatel 550 admissions. The service is a member of the Greater Manchester Critical Care Network (GMCCN).and for the purposes of governance, critical care sits in the trust's division of anaesthesia and surgery.

As part of the inspection we visited the units on 23 and 24 February 2016. We spoke with senior and junior medical staff, seven members of the nursing team, three members of support staff, one patient and one set of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

We have judged that overall, the critical care services provided at North Manchester General Hospital were good.

Critical care services were safe, effective, caring and well led. In terms of responsiveness the service required some improvement as patients did experience delays in being stepped down or discharged once deemed medically fit for the ward.

- There were systems in place for reporting and learning from incidents.
- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patient
- Care and treatment was planned and delivered in accordance with evidence based guidance.
- Critical care services were delivered by caring, compassionate and committed staff.
- We saw patients, their relatives and friends being treated with dignity and respect.
- There was a positive culture with staff and the public being engaged in the development of the service.

However

- It was rare for there to be a supernumerary clinical co-ordinator on duty as set out in the national service specification for intensive care (D16).
- There was a problem with delayed and out of hours discharges. The ICNARC data for January to June 2015 for the ICU showed that there were 28 reported delayed discharges from 121 admissions (23%) and

Critical care

22 out of hours discharges. For the period June to September 2015, the HDU reported 82 delayed discharges from 142 admissions (58%) and 15 out of hours discharges.

- Governance processes were present but yet to be embedded.
- The longer term future of the service at NMGH was still subject to debate and part of wider conversations regarding the on-going provision of healthcare across Greater Manchester.

Are critical care services safe?

Good

Overall in terms of safety, we judged that the critical care services at North Manchester General Hospital were good.

There were systems in place for reporting and learning from incidents. There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients although it was rare for there to be a supernumerary clinical co-ordinator on duty as set out in the national service specification for intensive care (D16). In December 2015 the formerly separate HDU amalgamated with the ICU to form a closed unit, physically in the same place on the ground floor of the hospital. This move and the associated refurbishment had improved the facilities available for patients and staff. There was an internal system for raising safeguarding concerns, staff were aware of the process and could explain what constituted abuse and neglect.

Incidents

- The trust had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff were familiar with the reporting system and were able to give examples of when they had used it.
- We saw a report extracted from the incident reporting system, which showed all incidents reported for the critical care areas within the trust for the period 01/12/2014 to 30/11/2015. As this report referred to the period before the unit amalgamated the incident numbers for the ICU and HDU were reported separately. The report showed that there had been 36 incidents reported for the ICU. Of these reported incidents there had been five medication errors, 3 were reported as causing a moderate impact and 13 were reported as having a low impact upon the patient (four of these low impact incidents related to the development of hospital acquired pressure ulcers). The remainder of reported incidents were rated as causing no harm. Of these remaining 18 'no harm' incidents there were three relating to out of hours or delayed transfer of patients to the ward.
- For the same time period there had been 83 incidents reported from the HDU. Of these reported incidents, there had been one near misses relating to an incorrect

diagnosis, two were rated and causing moderate harm, 19 were reported as having a low impact on the patients and the remaining 64 were reported as causing 'no harm'. Eighteen of the no harm incidents related to patients being moved out of hours, i.e. after 22.00 and before 07.00.

- Incidents were reported and discussed at the monthly critical care directorate meeting.
- Staff told us that incidents and learning was also shared during the daily safety 'huddles' on the unit.
- Monthly mortality and morbidity meetings took place in respect of the NMGH. Though from the records shared with us it was not clear who attended or what learning was being taken. The minutes were also short in detailing what the resulting actions were or who was responsible for taking them forward.
- Staff had varying levels of understanding about duty of candour. The trust had introduced training on duty of candour for senior nurses and managers within the trust but the detail and principles had yet to be embedded for all staff. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

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

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.
- We also checked the sluice area and commodes, which were clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- During the inspection we observed staff appropriately washing their hands, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care. Staff were adhering to the bare below the elbows policy.
- As previously stated the most recently validated ICNARC data reports from 2015, which was before the amalgamation of the ICU and HDU. The most recently supplied ICNARC data for the HDU (July to September 2015) showed no cases of unit acquired infections with Methicillin resistant staphylococcus aureus (MRSA) or Clostridium difficile (C diff). Infection rates were generally better than comparable units.
- For the period January 2015 to June 2015 on the ICU at NMGH, in terms of unit acquired infections in blood for ventilated admissions, performance was generally better than comparable units. For elective surgical admissions there were no cases of unit acquired infections in blood, although some data was missing. For emergency surgical admissions the last reported case of a unit acquired infection in blood was in 2010. Unit acquired MRSA and C diff infection rates were better than comparable units and no cases of MRSA bacteraemia had been reported.

Environment and equipment

- In December 2015 the formerly separate HDU amalgamated with the ICU to form a closed unit, physically in the same place on the ground floor of the hospital. Building works had been undertaken to provide twelve critical care beds including two siderooms. The usual split was six level 3 beds and six level 2 beds. Occasionally the unit had managed more than six level 3 patients. The decision to increase the level 3 patients on the unit was made by the divisional nurse and unit medical lead. There were no designated beds and the level 2 and 3 beds were used flexibly within the unit. With the merger of both level 2 and 3 areas the hospital lost two level 2 beds. We were told that hepatobiliary service had moved the Central Manchester releasing the capacity and reducing the impact of the merger and loss of level 2 beds.
- There was a blood gas machine, which was clean and maintained by the laboratory staff. We did observe a nurse introducing a blood sample into the machine without wearing any gloves or personal protective clothing.
- Not all the sharps boxes were appropriately labelled.

- Equipment (monitors, ventilators, pumps etc) was standardised between critical care units in the trust but not with theatres and accident and emergency.
- Details of both planned and unplanned maintenance were recorded and monitored by EBME on the trust wide electronic database system. Planned maintenance schedules were completed according to risk category, with high risk items taking priority. Equipment maintenance was performed by manufacturers, authorised service agents or in house staff. All equipment had a recorded date of when it was last serviced, with each item having its own unique identifier and maintenance history.
- There were resuscitation and difficult airway management trolleys, which were cleaned and checked daily and/or after use. The resuscitation trolley had a useful laminated colour picture of the layout, which demonstrated to staff how the trolley should look once checked and re-stocked.
- The was an emergency transfer trolley and associated kit stored in a alcove area within the unit. This was checked on a daily basis.

Medicines

- The unit used an electronic prescribing system (EPMA), which could be accessed at the bedside.
- The provision of pharmacy support to critical care did not meet the service specification and this may result in poorer patient care and unnecessary expense in medication use. The standard states that all critical care units should have a critical care pharmacist with 0.1 WTE per level 3 bed and 0.1 WTE for every two level 2 beds.
- The drug cupboards and storage was in an open plan area positioned between the two sides of the unit. Drugs were secured within lockable cupboards that had coded locks.
- We saw a locked drug fridge for which temperature checks and records were kept.
- The GMCCN review of May 2015 noted variation on medicines management practices across the trust. For example, drug concentrations and the use of potassium.
- Controlled drugs were stored in separate locked cupboards with the keys being held on the person of the nurse in charge of the shift. Controlled drugs were subject to a daily check.
- There were 13 medicines related incidents raised on the electronic system from the critical care unit at NMGH between 01/12/2014 and 30/11/2015.
- Unregistered healthcare practitioners were able to administer a restricted range of medicines once they had demonstrated the appropriate competencies and received the required training. For example, a 10 ml sodium chloride 0.9% flush after a cannula insertion.

Records

- We looked closely at two sets of patient records. The medical/nursing records were paper based and comprised a range of clinical records, assessments and plans. These included for example, VTE risk, delirium, nutritional risk, falls assessments, physiotherapy treatment plans and skin care bundles. One file was used for multi-disciplinary entries. All entries were completed, signed and dated.
- Although entries in records were signed and dated and in most cases included the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- Physiological parameters were recorded by the nurse looking after the patient on paper charts located close to the bedside. The charts that we looked at were comprehensively and accurately completed and brought together in one place all the patient's physiological monitoring, blood results, care planning and management.
- The unit was using electronic prescribing, which was accessed via a bedside laptop.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding training formed part of the trust's mandatory training programme. According to the figures supplied 97% of the registered nurses on the unit had completed level 2 safeguarding training for both adults and children.
- The trust had named nurse leads for safeguarding adults and children.

Mandatory training

- The practice based educator had oversight of the nurses mandatory training. There were records kept of the trust

mandatory training, which included fire prevention, infection prevention and control, moving and handling, hand washing, information governance, equality and human rights, safeguarding adults and children (level 2), risk management, health and safety and waste management. The records indicated the frequency of each subject. For example, information governance training was required annually whilst safeguarding training was undertaken every three years.

- The most up to date mandatory training records seen for the critical care units at NMGH were from November 2015. They showed that the overall mandatory training compliance rate was 91% and 84% for the outreach team.
- Additional training required for critical care staff was delivered on training days set up on the unit. For example, dementia training, mental capacity, blood transfusion, fire lecture, delirium update and administration of intra-venous opiates.

Assessing and responding to patient risk

- A range of patient risk assessments were undertaken on admission and repeated on and on-going basis as required. These included for example, nutritional risks and the risks of developing pressure ulcers.
- The wider hospital used an early warning score system (EWS). EWS systems were introduced with the aim of providing a simple scoring system, which could be readily applied by both nurses and doctors to help identify early and quickly deteriorating patients. The EWS uses an aggregated weighting system with physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation.
- Training in the use of EWS for ward staff was facilitated by the hospital's critical care outreach team (CCO). The CCO comprised six band 7 practitioners (4.2 WTE).This enabled an outreach service at NMGH from 07.45 to 20.15, seven days a week. Overnight the outreach bleep was carried by the night clinicians. We saw that the outreach staff finished there long day at 20.15, this was before the night clinicians started their shift. So we asked about handover. Staff told us that the handover from the outgoing critical care outreach staff to the night clinicians was by password protected email. So it was not face to face. We were told by staff that if there were any specific patient concerns then the outreach staff would just stay untilt he night time started their shift.
- The function of the outreach team was to identify patients at risk of deterioration by championing the EWS and trust escalation policy, to provide monitoring and support for patients discharged from critical care and so prevent any readmissions, teaching ward staff and assisting with the management of patients deteriorating who required admission for level 2 or 3 care and treatment. The outreach nurses also dropped into critical care each morning to see if there were any patients due for step down to the wards.The outreach service covered all the ward areas and the medical assessment unit at NMGH.

Nursing staffing

- On the day of inspection both the critical care unit was safely staffed in terms of the numbers of bedside nurses on duty. Based on the intensive care society acuity standard there should be one nurse for every level 3 patient and one nurse for every two level 2 patients, to deliver direct care. These are the expected staffing levels irrespective of the shift, both day and night. The unit had requested additional staff and during the morning shift on the 24 February a trained nurse arrived from the unit at the Royal Oldham Hospital to augment the staff numbers. The aim was to have 10 trained nurses on an early shift.
- The unit did not meet the standard for supernumerary cover. The intensive care society standard states that there will be a supernumerary clinical co-ordinator at band 6/7 on duty 24/7. We were told that this rarely occurred and then when it did it was only on the early shift. The nurse in charge of the each unit was working clinically to care for patients. This issue was well known to the trust and was highlighted as a concern in the May 2015 review by the GMCCN.
- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers.
- There was a critical care nurse matron based on the NMGH site.
- Along with the other critical care units in the trust, the nursing budget was subject to a £140,000 cost improvement plan for the coming year.

Critical care

- No agency nurses were used. Any extra shifts were carried out by the unit's own staff that were duly paid an overtime rate.
- Shift to shift and bedside handovers were undertaken morning and evening.

Medical staffing

- There was a named clinical lead and 8 critical care consultants supported by trainee medical staff for the critical care services. Three of the consultants were fellows of the Faculty of Intensive Care Medicine (FICM) and two had completed the European diploma in intensive care medicine (EDIC). The clinical lead had only 0.5 of a programmed activity for the lead aspects of the role.
- The consultant team provided full session day time cover. Evening and weekends were covered by a weekend day session and on call out of hours. Consultant was available 24/7 and available within the 30 minute travel timeline. The unit was currently holding 2.5 WTE consultant vacancies and historically, we were told, there had been difficulties in recruiting.
- Out of hours there was one resident middle grade doctor with a consultant on call. On occasions they may have to go to the emergency department but did not have any theatre or maternity theatre responsibilities when on duty overnight. No foundation level doctors were ever left as the sole doctor in critical care.
- FICM regulations for training were all in place.
- Clinical consultant led ward rounds took place twice a day, seven days a week.
- A structured consultant to consultant shift handover took place.

Major incident awareness and training

- The major incident policy was easy accessible on the trust intranet and was last ratified in February 2015.
- We saw no specific surge or business continuity plans for the critical care service at NMGH.

Are critical care services effective?

Good

We have judged that in terms of effectiveness, the service provided at the critical care unit at the North Manchester General Hospital was good.

Care and treatment was planned and delivered in accordance with evidence based guidance. There were competent staff in place supported by a full-time practice based educator. The unit contributed data to the intensive care national audit and research centre (ICNARC). Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.

Evidence-based care and treatment

- The unit demonstrated continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the Greater Manchester Critical Care Network (GMCCN). The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust wide intranet.
- Trust wide there was non-compliance with aspects of NICE guidance 83 'Rehabilitation after critical illness'. The trust had carried out a gap analysis to identify the areas of non-compliance though this wasn't disaggregated for the individual hospital sites. Though it is a fact that the outreach service at NMGH does not include a follow clinic for patients.
- We saw a trust wide critical care audit plan, though it was not clear if all the audits had yet taken place.
- A network skin bundle audit, September 2015, showed good levels of skin bundle compliance for both admission and on-going care actions, aside from April 2015 where compliance dropped significantly to 30% for the two hourly re-positioning standard. It was though that this level of non-compliance was related to poor documentation rather than poor care.
- We saw evidence of ventilator acquired pneumonia audit results displayed in poster form on the unit corridor near the staff room.

Pain relief

- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a paper based pain scoring tool.
- We were told that referrals were made the hospital's acute pain team as necessary.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately in the patient's notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- Dietetic advice was available and the dieticians did attend the unit although were not regularly part of the daily ward rounds.

Patient outcomes

- The critical care unit at NMGH contributed data to the national database for intensive care (ICNARC), which enabled their respective performance and outcomes for patients to be benchmarked against similar units nationally.
- The most recent ICNARC data shared with us was for the July to September 2015 quarter. As this was before the units amalgamation the ICNARC results are reported for the former HDU and the ICU. The data for the HDU showed that from July to September 2015 there had been 142 admissions, 59% were male and the average age was 60 years. Twenty three percent of the admissions were elective or scheduled and 56% of admissions were non-surgical in speciality. In terms of early readmissions the unit was performing generally similarly or slightly better than comparable units. For mortality, there had been 21 observed deaths against the expected 17.7 using the ICNARC (HDU) model giving a mortality ratio of 1.19. This was within the expected limits for comparable units.
- The data for the ICU for the same period showed there had been 121 admissions, 53% were male and the average age was 54years. Only 7% were elective or scheduled admissions and 68% were non-surgical. For the last quarter mortality for ventilated admissions was better than comparable units though the length of stay was greater. The numbers of unit acquired infections in blood was better than comparable units. For admissions with severe sepsis mortality was slightly worse than for comparable units and again the length of stay was greater. For admissions with trauma, perforation or rupture the mortality rate was lower than comparable units. For admissions with pneumonia, mortality for the last quarter was much better than comparable units although length of stay was longer. For emergency surgical asmissions the mortality rate for the most recent quarter was similar to comparable units, Using the ICNARC (2013) model the mortality ratio was 1.24 with 29 observed deaths against an expectation of 23.3. This was within the expected limits for comparable units.

Competent staff

- Nursing staff were appropriately trained, competent and familiar with the use of critical care equipment.
- There was a full time practice based educator.. As with the other practice based educators in the trust, there were four in total, they were unit based. Funded by the critical care network they also worked part of their time with the Skills Institute. They were responsible for new starters for the first twelve months of their employment and worked alongside new staff to support them through the Step one critical care competencies. Once the Step one competencies had been completed then nurses were eligible to apply for the critical care course run in conjunction with Manchester Metropolitan University. At the time of inspection 75% of the trained nurses in the critical care units at NMGH had completed the critical care course.
- All nursing staff had to undertake an assessment package before they were judged as competent to administer intra-venous opioids by bolus injection.
- The practice based educators were also responsible for completing the first personal development review (PDR) for new staff.
- The practice based educator was proud to tell us of the projects that the team had been involved with, which included undertaking acute illness management courses (AIM) in Uganda and India, local multi-disciplinary simulation training (for which they had been nominated for a national award) and both acute hospital and community tracheostomy policy and practice.

- Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- All staff were subject to an annual appraisal. According to the data supplied by the trust the latest available figures showed that 64% (against a target of 90%) of registered nurses in critical care at NMGH had so far received an appraisal in 2015/16.
- The health care assistants were also able to develop by undertaking modules in physiological observations such as blood pressure, temperature and pulse. They also had an opportunity to complete the acute illness management course (AIM).
- The unit also provided a training placement pre and post registration students from Salford University, Manchester University and Manchester Metroplitan University as well as midwifes and paramedics.

Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place each day on the ICU. Although members of the multi-disciplinary teams attended at some point during the day they did not always attend at the same time.
- We saw good multi-disciplinary working between nurses and allied health professionals on the unit.
- The recognition of and management of the deteriorating patient at ward level sits within the national critical care specification (D16). There is a requirement to undertake as a minimum an annual audit on the quality of clinical observations and effectiveness of the track & trigger system being used. The outreach team at NMGH looked at their activity for the period 01/01/2015 to 30/11/2015 and produced the following analysis;
  - Total of 1686 patients seen.
  - 666 level 2/3 patients followed up.
  - 471 patients triggered on early warning system (EWS).
  - 3 with acute kidney injury.
  - 45 cardiac arrests.
  - 115 patients causing concern and seen though not triggering on EWS.
  - 379 requiring specialist help.
  - 3 patients with a laryngectomy.
  - 4 patients with tracheostomy.

Seven-day services

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

Access to information

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

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

- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.
- We did not see any deprivation of liberty applications for patients in the critical care unit, though were told that a recently discharged patient had been subject to one because of their age. We followed this up with a visit to the ward to which the patient had been discharged. On examination of the patient's records we found a referral to the safeguarding team and not a deprivation of liberty application.

Critical care

- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient.
- The trust had developed a delirium prevention care bundle, which had been adopted by the GMCCN. Although its understanding and application had yet to be thoroughly embedded into practice.

Are critical care services caring?

Good

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

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Privacy curtains were drawn around people with appropriate explanations given prior to care being delivered.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with people so that where possible they understood their care and treatment. This was corroborated by a patient that we were able to speak with during the inspection.
- We spoke with one patient and their relative on the unit. They were universal in their praise for the staff. Reporting that they had been kept informed of everything that was going on.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- We asked about the use of patient diaries for patients who were sedated and ventilated. However, whilst the staff stated that they would like to introduce them, they were not using them at the time of the inspection. Intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- There was a senior nurse for organ donation in post who worked closely with the critical care team in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- Leaflets were available on the units which gave patients and their families' information about the spiritual care team, which provided emotional support and religious care across all the trust's hospital sites. Referrals to the team could be made at any time by telephone or by completing an online form found on the trust intranet.
- Posters were on display that gave the contact details for the hospital chaplaincy service which was contactable at any time.
- Patients and relatives also had access to the information and advice service (PALS), which had been relaunched in January 2016 and included an onsite office located in the hospital's main reception area.

Are critical care services responsive?

Requires improvement

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

The latest ICNARC data available related to the time prior to the amalgamation of the level 2 and level 3 service. Consequently, the ICNARC data is reported separately for level 2 and level 3 care. There was a problem with delayed and out of hours discharges. The ICNARC data for January

to June 2015 for the ICU showed that there were 28 reported delayed discharges from 121 admissions (23%) and 22 out of hours discharges. For the period June to September 2015, the HDU reported 82 delayed discharges from 142 admissions (58%) and 15 out of hours discharges.

Service planning and delivery to meet the needs of local people

- The trust had adopted an innovative approach to redefining its vision and values and developing its five year strategy by engaging with staff through a 'crowd sourcing' approach. Crowd sourcing is the practice of engaging a 'crowd' or group for a common goal, usually on-line, often for innovation, problem solving, or efficiency. A key component of the trust's strategy was the transformation of clinical services across the trust. This work was taking place alongside the associated complexities of health and social care re-configuration in Greater Manchester. Whatever the future re-configuration of health services looks like, there will be implications for critical care services at NMGH.
- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.

Meeting people's individual needs

- Patients on critical care were reviewed in person by a consultant intensivist/anaesthetist within 12 hours of their admission.
- Care plans demonstrated that people's individual needs were taken into consideration before delivering nursing care.
- There was an outreach service within the hospital. The outreach team followed up all patients discharged from critical care.
- Interpreting services were available within the hospital if required.
- The latest available (ICNARC) data related to the a period prior to the amalgamation of the level 2 and level 3 units. This showed that for the former HDU the early readmission rate was slightly better than comparable units but the late readmission rate was slightly worse. The numbers of transfer out (clinical and non-clinical) were much better thanin comparable units. The level 3 ICU submitted its ICNARC data separately and it showed that for early and late readmissions the unit was now performing better than comparable units. For transfers out the unit was performing generally the same as comparable units.
- The senior nurse for organ donation (SNOD) was based on the Royal Oldham Hospital site but did cover the whole trust. All patients for whom a decision to withdraw treatment was made were referred to the SNOD.
- There were facilities for patients' visitors to sit and wait, these included a room where overnight stay was possible.

Access and flow

- The bed occupancy figures related to the period prior to the amalgamation of level 2 and level 3 services. So were of limited value in reflecting the current bed occupancy of the new unit.
- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from critical care there was often a delay in discharge.
- There was a problem with delayed and out of hours discharges. The ICNARC data for January to June 2015 for the ICU showed that there were 28 reported delayed discharges from 121 admissions (23%) and 22 out of hours discharges. For the period June to September 2015, the HDU reported 82 delayed discharges from 142 admissions (58%) and 15 out of hours discharges. We noted from the incident reporting data that out of hours discharges were reported. Access and flow performance was tabled at the monthly critical care directorate meetings, though it is not clear from the minutes what actions, if any, the unit are taking to try improve the position for patients.
- As a consequence of access and flow issues within the hospital, during the 12 months from December 2014 to December 2015, 6 patients had been ventilated outside the critical care unit. This usually took place within the theatres when the patients were looked after by the duty anaesthetist supported by theatre recovery nurses and operating department practitioners.

Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns.

- Complaints were made in writing or electronically to the Chief Executive or to the Complaints Department, or via the trust website. The trust website provided details on how to do this and the complaints handling policy was available online. Leaflets were available throughout the trust, detailing the routes available in resolving concerns. Local resolution was encouraged to resolve concerns at ward level and if unsuccessful, the PALS service can attempt to resolve concerns. PALS aimed to resolve concerns but they provided information about the trust's NHS complaints procedure and provided support if concerns could not be resolved. Effective from February 2016, PALS offices were based at each hospital site.
- The trust complaints annual report was presented to the Board of Directors and shared with commissioners. The trust board received a quarterly Learning from Experience (LFE) report that included details of complaints and PALS contacts received the previous quarter, with associated trends or themes.
- We did not receive any specific information about complaints or concerns from the critical care services at NMGH. We did see a spreadsheet detailing incidents and complaints that was tabled at the November 2015 critical care directorate meeting but the page relating to complaints was blank

Are critical care services well-led?

Good

We judged that the critical care service at North Manchester General Hospital was well led.

There was both nursing and medical clinical leadership, who had led the service through the recent amalgamation of the former 'open' HDU and the intensive care unit and into the new 'closed' twelve bedded critical care unit. Governance processes were present but yet to be embedded. There was a positive culture with staff and the public being engaged in the development of the service. The longer term future of the service at NMGH was still subject to debate and part of wider conversations regarding the on-going provision of healthcare across Greater Manchester.

Vision and strategy for this service

- The critical care service at NMGH had until December 2015 been run as two separate units with the high dependency unit being open to referrals from all specialities within the hospital. In December 2015 the HDU amalgamated with the ICU to create a combined 'closed' critical care unit for six level 2 and six level 3 patients.
- The trust has recognised in its five year strategy that there are several options for the re-configuration of critical care pathways and services across the whole trust and they remain subject to debate and ultimately public consultation.

Governance, risk management and quality measurement

- Governance processes in the critical care directorate were still evolving since the appointment of the new triumpherate management team. Critical care directorate meetings were held monthly and attended by the directorate's management triumpherate comprising, medical, nursing and business leads. The minutes of the October 2015 meeting state that there was still a need to appoint a governance lead for the directorate. It was not clear how the critical care risks were escalated within the organisation so that the board were aware of them.
- The risk register was held at directorate level. It did contain a number of risks common to all critical care units within the trust, some of which had been on the register for more than two years. For example, the shortfalls in meeting the national service specification for critical care (D16).
- Performance reports were being produced monthly to demonstrate activity within the critical care units.
- The unit contributed data to the intensive care national audit and research centre (ICNARC).

Leadership of service

- There was a new triumpherate management team for critical care in the trust comprising medical, nursing and business managers.
- There was a designated medical clinical lead for critical care.
- Nursing staff knew who their managers were. There was a critical care matron based on the North Manchester Hospital site.
- We were told that the executive team had been more visible of late and members had visited the unit.

Critical care

Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care.
- Staff were keen to tell us about the recent merger and how they had embraced this change and could see the benefits for patients of the new 'closed' unit.
- Staff were encouraged to report incidents and raise concerns.
- We asked staff about their understanding of 'duty of candour' and obtained mixed responses.

Public engagement

- The trust website provided some helpful information about critical care services in general.
- Whilst the unit did display information about visiting times, we heard from both staff and relatives that visiting was at the discretion of the nurse in charge and exceptions were often made to allow relative's to visit their loved ones.
- The trust had involved public members and wider stakeholders in developing its new quality strategy.

Staff engagement

- In the wider trust, staff had been consulted and involved in co-creating the organisation's new values, new goals and new five year transformation plan.
- Staff reported that they had been involved and consulted in respect of the recent building works undertaken to update the critical care facilities.
- The trust had developed a range of communications to help to staff to celebrate their success such as the 'Pride in Pennine' publications, staff awards, Monday Message and the 'Pennine News' newsletter.

Innovation, improvement and sustainability

- The practice based educators were also involved in acute illness management training (AIMS), teaching on the critical care course, ALS/ILS training, audit and medical devices training.
- The critical care matron (based at North Manchester General) had developed an evidence based delirium strategy, which had been adopted by the critical care network.
- The critical care outreach team at NMGH was involved in a range of service developments such as; tracheostomy support and training, management of sepsis, acute kidney injury (AKI) and training and support of ward staff on the early warning systems. The unit was also involved in the RiCON project (Risk over network). This project aims to improve patient safety within the critical care network by allowing different units to share problems and best practice to improve the quality of care offered to all critical care patients. The project focused on 6 main areas of risk: infection and ventilated acquired pneumonia, communication failures, lack of access to critical care, harm from mechanical ventilation, medication safety and airway safety.

Maternity and gynaecology

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

Information about the service

North Manchester General Hospital was one of two hospital sites of The Pennine Acute trust which offers both outpatient and inpatient maternity services. The hospital provides pregnant women and their families antenatal, delivery and postnatal care. The department delivers approximately 4,557 babies every year. Emergency gynaecology services are offered at this hospital.

The Women's unit occupies three floors of one wing of the hospital. There is a separate entrance with drop off parking for the delivery suite away from the main accident and emergency entrance. There is a consultant led delivery suite with ten rooms, including one high dependency room and one birthing pool. There is a midwifery led birthing centre with five delivery rooms, three of which had a birthing pool. Ante-natal inpatient care is delivered on a 28 bedded ward and there is a 28 bedded post-natal ward. There are two obstetric theatres which are situated adjacent to the delivery suite with a two bedded recovery area. Maternity triage is situated in the main hospital on the ground floor. This provides four triage rooms and an antenatal day unit with four beds. This is adjacent to the ante-natal clinic. There are two examination rooms in the gynaecology clinic and a room for patients to have scans.

The community midwives are split into geographical teams. They cover a large area including Rochdale, Oldham and Fairfield where there used to be inpatient provision.

We visited the maternity department during the announced inspection on the 23rd and 24th of February 2016 and the 2nd of March 2016. We carried out an unannounced inspection on the 17th March 2016. During our visit we spoke with 40 staff, 5 patients and two family members. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 14 patients. We also looked at five medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

Over all we found the service Inadequate.We found maternity and gynaecology services to be inadequate in terms of being safe and well led, require improvement in terms of being effectiveand responsive We found them good in terms of being caring.

- There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm.
- There was a failure to effectively investigate and learn from incidents with a lack of openness about outcomes.
- There was a lack of learning from complaints and a lack of learning and sharing of knowledge from discussions about mortality and morbidity.
- There was a lack of accurate record keeping including Early Warning Scores (EWS) for adults and neonates, consent forms and surgical safety checklists.
- There was a shortage of midwifery staff which led to some delays in transfers during labour and inductions of labour.
- There was high midwifery sickness and vacancy rates and gaps in the consultant cover. Audits of the quality of service provided had taken place; however there was a lack of actions to make identified improvements.
- Mechanisms for collating data were not used to inform and improve practice.
- Midwives and medical staff were not up to date with training and competence for some of the tasks they performed.
- The average length of stay was longer than the trusts target. The maternity triage unit was relocated at night due to shortage of staff.
- There had been a focus on the maternity improvement plan which was developed following the external review in January 2015; however there was no strategy for continuous improvement or sustaining the changes which had been implemented.
- There was a lack of clear systems and processes for managing risks and performance of the service. There were few mechanisms for staff engagement and plans to improve this had not taken place.
- Some improvements in public engagement had occurred; however plans for others had been postponed. There was little encouragement for innovation from staff.

However some improvements had been made as a result of the maternity improvement plan including the purchase of necessary equipment. Midwifery and medical staff worked well as a team and provided compassionate care despite the shortage of staff. There was an enthusiasm amongst the staff to improve the services. The bed occupancy was lower than the England average and there were good processes in place for discharge of patients.

There is consultant and junior tier medical staff available to support emergency gynaecology care, there are 3 emergency beds which are allocated for gynaecology .

There were changes in the leadership of the service following our inspection. Between the announced and unannounced inspection some practical changes had been made and staff told us there was already an improvement in communication. We were given assurance that immediate changes had taken place to address concerns about staffing levels that were raised during our inspection.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

We rated maternity and gynaecology services at North Manchester General Hospital inadequate for safety for the following reasons:

- An independent review into nine serious incidents in the maternity services at the trust had been completed in January 2015. The recommendations made had not been put into practice in the management of incidents we reviewed.
- There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm
- There was a lack of learning and sharing of knowledge from discussions about mortality and morbidity.
- Specific training following previous poor clinical outcomes in infection rates had not remained up to date two years later.
- There was inconsistency in the completion of patient record keeping and other required documentation.
- Not all staff were up to date with mandatory training.
- Assessments to identify patient's clinical risks had not been completed in line with the trusts' policy.
- Records for the monitoring of patients, including neonates, to detect deterioration in their condition were not accurately completed.
- There was inconsistency in the escalation of patients for medical review. Records showed the recommended safety procedures for patients having surgical operations in theatre were not followed.
- The midwifery staff to patient ratio was worse than the England average and the labour ward frequently had lower than the planned number of midwives working.
- Midwives were not achieving one to one care in labour. Midwife sickness and vacancy levels were high.
- The escalation policy was limited in its usefulness due to a lack of midwives to redeploy.
- Whilst there were some delays in patient care due to low staff numbers these were limited due to staff of all grades working extra hours and through their breaks to support patients.
- There were gaps in resident consultant cover for obstetric services and concerns about on call support for junior doctors.

However

- The maternity services were visibly clean and infection prevention and control measures were in place.
- An increased amount of equipment, including monitors for assessing the health of the unborn baby, had been purchased as a result of the maternity improvement plan.
- The midwifery led birth centre offered a very homely environment.
- Medicines were safely stored and the required records were kept.
- A document to improve the handover of care between health professionals had been developed as part of the maternity improvement plan.

The trust responded promptly and took appropriate action to mitigate immediate risks following our inspection. During our inspection a safeguarding concern was identified in the obstetric theatres and action had been taken to address this at the unannounced inspection. The procedure for patients who presented at the maternity assessment unit were changed following the inspection to ensure a more timely assessment of their risks.

Incidents

- An independent review into nine serious incidents in the maternity services at the trust had been completed in January 2015. Following this several recommendations were made which included; clarifying the process for escalating concerns, a quality check for incident reports to ensure the root cause was clearly established, recommendations must be clear and unambiguous and where individual failings had been identified reports must demonstrate education and training had been considered. These recommendations had not been put into practice in the management of incidents we reviewed. We saw reports with no recommendations or learning points recorded, staff, including senior managers, were unaware of the outcomes of serious incident investigations and the process for quality checking of reports was not understood by those completing investigations.

Maternity and gynaecology

- In the past 12 months the trust had reported 32 serious incidents in maternity services. Of these 21 had been reported retrospectively as the need to do so had not been identified at the time.
- One investigation report into a serious incident that we reviewed had not been completed until during our inspection which was four months after the event. This was not in line with the trusts' policy of completion of the investigation within 60 days. There were no recorded learning points from this incident and no action plans despite the report identifying "multiple omissions in delivery of care, poor clinical decision making and failure to escalate". Medical and midwifery staff of all grades were unaware of the outcomes of this investigation.
- There was a delay in the management of incidents in the maternity services. Information provided by the trust of analysis of incidents between 1 October 2014 and 21 February 2016 showed there were 170 unclosed incidents in maternity and gynaecology services. The majority of open incidents at 104 were in the labour ward. 44 of these incidents involved moderate harm, eight severe and five death of a patient. This information was not separated into the two maternity hospital sites.
- Ward managers had a lack of protected management time and had a backlog of incidents to investigate.
- The system for monitoring incident reports, investigations and outcomes was ineffective. A monthly multi-disciplinary risk meeting took place where clinical incidents were discussed. Minutes from three consecutive meetings showed a lack of medical representation. There was no resulting action plan documented for any meeting and no mechanism for documenting themes or trends and resulting actions.
- Failure in the management of incidents was on the maternity and gynaecology risk register. One of the actions to monitor this was "regular auditing of the process" which had a target date of 31 January 2016. At the time of the inspection no audits had taken place.
- We were told the immediate learnings from one serious incident had been included in the maternity improvement plan; however we found this not to be the case. Perceived improvements included ensuring early warning scores were completed and appropriately escalated but we found seven we reviewed were incomplete.
- Staff knew how to report incidents. In some areas they discussed how issues which should be reported as an incident had become accepted practice and therefore were not reported. One example was the relocation of the maternity assessment unit from the permanent facility to be temporarily relocated on the ante-natal ward.
- There was a lack of written and verbal information sharing of learning from incidents. This should have been in place as a result of the maternity improvement plan.
- A newsletter to share themes from incidents disseminated via email had been developed the day before our visit.
- Consultants had investigated incidents when they had been part of the clinical team which provided care. They thought this was due to a lack of understanding of the process by directorate managers.
- Staff were unclear how they would be informed if they were part of an incident investigation. They told us there was no culture of learning from incidents in a positive way and their experience of being involved themselves was punitive. For some this was a deterrent to reporting incidents.
- 21 staff including matrons, ward managers and consultants had completed a two day training course in effective root cause analysis investigations following an incident. This had been one of the recommendations of the external review.
- The consultant with the lead for risk had three hours per week allocated to the process of incident investigation. This was insufficient to complete the required tasks.
- There were 51 unclosed incidents in the gynaecology services within the trust. Of these three were graded as severe.
- There was low attendance at the monthly multi-disciplinary mortality and morbidity meetings. Of 17 clinicians two attended five times in the past 12 months with the others attending less. There were five meetings of the past 12 when no midwifery managers attended. It was recorded that staff were expected to achieve 70% attendance however no clinicians met this target.

- Junior doctors presented cases at the monthly mortality and morbidity meetings with consultant support. They did not know how the outcomes of the discussions and presentations were recorded or used to learn any lessons.
- On the minutes of the trust wide mortality and morbidity meetings we reviewed up to January 2016 there were no actions recorded. This despite learning points recorded which identified actions were required including guidelines not being followed and appropriate translators not being available during the night. The minutes for the January 2016 meeting showed improvements.
- Senior staff we spoke with were aware of the duty of candour; however we did not see recorded evidence of this. We did see that relatives in the case of one serious incident had been informed there would be an investigation nine days after the incident. They had asked for clarity around several issues and there was no documentation that this had been provided at the time of the inspection which was four months later.

Safety thermometer

- The specific maternity safety thermometer information was gathered from the birth centre, post natal ward and community midwives. This information was not displayed. This is a point of care survey that is carried out on one day per month in each maternity service on all postnatal mothers and babies who consent to take part. Data provides a 'temperature check' on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for patients.
- Safety thermometer information from the trust showed in January 2016 there were 46 patients with perineal trauma and 47 in February. Seven patients had infections in January. Midwifery staff were unaware of this information and how it was to be shared or used.
- The information from the general safety thermometer was displayed which included the number of falls and infections each month. This meant maternity specific harms such as perineal and/or abdominal trauma, post-partum haemorrhage and puerperal Infection were measured but not displayed or used to inform changes in practice.

Cleanliness, infection control and hygiene

- All areas of the maternity services were visibly clean.
- The trusts' cleaning audit showed between November 2014 and November 2015 the birth centre averaged 100%. No areas scored as high risk with the delivery suite being amber overall at 92.10% against the target of 95%.
- Hand gel was available at the entrance to all wards and departments. We observed staff using it and reminding visitors and patients to do the same.
- The trust did not provide specific hand hygiene audit data for this hospital site.
- Information provided by the trust showed there had been no MRSA or Clostridium Difficile in the maternity services between April and December 2015.
- Following higher than national incidences of puerperal sepsis in 2013 an action plan had been developed to ensure the rates were reduced. Aseptic non touch technique training was part of this plan. Information from the trust showed 65% of nursing and midwifery staff and 57% of staff in additional clinical services were up to date with this training. This meant not all staff who delivered care were up to date with this training. The trust was not compliant with this action they had identified to prevent puerperal sepsis.
- On the labour ward there was no infection control information displayed such as results of hand hygiene audits or infection rates. This should be displayed as part of the safety thermometer data. This information was present on the other wards maternity and gynaecology wards and showed between 95% and 100% for the hand hygiene for the previous month.
- The service did not provide surgical site infection information. They told us "due to the nature of Obstetrics and Gynaecology surgery and associated short length of stay in hospital, this is not currently mandated for this speciality." However there was some ongoing consideration as to whether this information should be audited.
- Waste was segregated and stored appropriately in all areas.

Environment and equipment

- Increased equipment had been made available as part of the maternity improvement plan. Staff told us this included CTG machines, blood pressure monitors and doplar equipment.

- Adult resuscitation equipment was available in all clinical areas. Records showed these had been checked daily.
- Resusitaires for neonatal resuscitation were present in the required areas. On the labour ward records for six resuscitaires showed they had not been checked on a daily basis as per the policy. In February these had not been checked on four occasions. Those on the postnatal ward had been checked daily.
- Staff discussed some concerns about the distance they would need to transport a patient on the public corridor between the maternity assessment unit and the labour ward. They had raised this concern but were unsure if there was a risk assessment completed.
- The midwifery led birth centre had homely fixtures and fittings and was not clinical in appearance. There were four rooms with a double bed which pulled down from the wall, adjustable soft lighting, non -clinical cots and three rooms had birthing pools. The décor was domestic in nature and the area was close enough to the maternity unit if required in an emergency, but was separate from the consultant led area. This area provided a very calm area for low risk patients.
- There was one birthing pool on the delivery suite.
- There was a bereavement room on the labour ward which we could not view during our visit.
- There was a shortage of storage space in most areas; however items were stored so as not to cause obstruction to exits or hazards to patients.

Medicines

- Medicines including controlled drugs were securely stored.
- Daily checks of controlled drugs by two people took place. These were recorded and records we reviewed showed they took place daily. A weekly check by the manager was recorded which provided additional oversight.
- Guidance notes on the correct completion of the controlled drugs book was documented in the book. This included the correct way to make changes to documentation.
- Medicine fridge temperatures had been checked daily and recorded.
- Intravenous fluids were securely stored.
- An electronic medicine administration system was used. The midwives had a portable medicine trolley and computer which was shared between the various accommodation bays on the ward.
- There was a dedicated pharmacist to each ward. They provided daily visits to check stock items and provided additional support if required such as administration of complex medicine regimes.
- Anticipatory prescribing was seen where appropriate such as intravenous fluids if a patients' blood pressure fell below a specific reading.

Records

- Records on the maternity unit were securely stored in locked cupboards or cabinets. In some places these were positioned so as not to be readily accessible to the general public, however on other wards they were in the general communal areas and the keys were in the locks.
- In the maternity assessment unit an assessment record was completed when a patient was transferred from the care of one professional to another. This included between the maternity units. The preliminary findings of an unclosed serious incident indicated a lack of documentation when a patient's care transferred between care professionals to have impacted on the negative outcome. This documentation had been introduced several weeks ago as part of the maternity improvement plan.
- The records for safety checks on closing and re-opening the maternity assessment unit had not been completed for example the last one was dated 10 February 2016 although the unit had been closed the night before our visit. All the information required was not recorded such as who authorised the closure and the security of the area including medicines.
- There was duplication of patient records due to midwives hand writing in the notes and then putting the same records into the electronic record system. This system did not contain all the same information as the paper records and therefore both systems were currently required. Staff were unaware of the plans to reduce the need for this.
- The "red books" for babies' health records were used.
- The completion of care plans was inconsistent. In some patient records care plans were completed and in others they were present but were blank. This included for the management of peripheral vascular devices.

- A patient's fluid intake and output was not always accurately recorded. We reviewed seven fluid intake and output charts. Four had not been fully completed and this included no recorded totals, one output and intake recorded in 24 hours and another with no intake recorded.

Safeguarding

- Staff training in the safeguarding of children did not meet the trusts' target for all staff groups. Information provided by the trust showed 75% of midwifery registered staff had completed level 2 safeguarding children training and no community midwives in the North area had been trained in safeguarding children to level 3.
- If a patient with an appointment at the antenatal assessment unit failed to attend they would receive a telephone call from the staff and if there remained concerns a home visit by the community midwives would be requested. We saw records of this follow up having taken place.
- In the recovery area of the obstetric theatres there were two resuscitaires where babies were brought straight from theatre. Due to the urgency of treatment required this would be done without the babies being labelled therefore there was a risk of incorrect identification if two babies were in this area at the same time. At the unannounced inspection on 17 March 2016 a system of labelling the baby prior to leaving theatre had been introduced.
- Community midwives were provided with lone worker security devices to alert security personnel if they were at risk. One midwife told us theirs did not work and had not done so for some time. They had reported it but had no replacement provided.
- Midwives had received training in the support of patients who had female genital mutilation including what they needed to report and how to do this.
- The personal information for some patients was not protected. Midwives who provided telephone support to patients did not have a mobile phone provided and used their personal phone.

Mandatory training

- We did not obtain an overall figure for the mandatory training in the maternity services. Information provided was split into the 11 subjects which made up this training. 90% or more of staff were up to date in six areas. These topics included hand hygiene assessment, equality and human rights and information governance. For the remaining five areas the trusts target of 90% was not reached with the lowest being health, safety and welfare level 1 which 76% of staff had completed.
- There was a public health training day which included topics such as care of patients with a high body mass index (BMI), domestic violence and breast feeding. Maternity medical staff and midwives were expected to attend every two years.
- Whilst some specific training had been deemed to be mandatory, such as Cardiotogography (CTG), staff were not allocated time to complete this. Where this was e-learning it was accepted midwives would complete it in their own time. Information from the trust showed in January 2016 74.4% of midwifery staff and 69.2% of medical staff were up to date with CTG training. This did not meet the trusts' target of 95%.
- Whilst midwives understood the need to complete mandatory and additional training they cited working extra shifts and not being released for training as reasons for not being up to date.

Assessing and responding to patient risk

- Risk assessments had not been documented in the hand held notes at each trimester. We reviewed seven patients' notes and none had the required assessments completed in line with their due date.
- In these notes two of the seven patients had not had their risk of venous thromboembolism completed.
- Early warning scores were not fully completed to ensure they could be used to assess the potential clinical deterioration of a patient. We reviewed seven early warning scores and none had been completed fully. As all the parameters were not completed the score could not be accurate and therefore the decision to escalate or not was based on insufficient information. One example was a patient who had scored 4 at 01.40 had their observations recorded again at 01.45 and 02.05 however neither of these had been totalled to determine the overall score. There was no record of a medical review for the patient when they had scored 4 despite this being the protocol which should take place.
- The early warning scores were not discussed verbally as part of the handover of care from one midwife to another in all areas of the maternity services.

- There was no neonatal early warning score used to detect deterioration in the condition of a new born. An observation chart was used; however this did not facilitate the observation outcomes to be calculated in order to identify an overall score. It did not meet the recommendations of the British Association of Perinatal Medicine (BAPM) which is that the tool should seek to "provide a visual prompt to aid identification of abnormal parameters by colour coding e.g. red, amber, and green". Midwives on the postnatal ward identified this as a concern especially since it was planned that nursery nurses would be responsible for completing and recording neonatal observations in the future. There were plans to introduce a score to meet this standard, however staff did not know any timescales.
- Improvements in the use of Cardiotogography were identified in the maternity improvement plan. This included the purchase of new monitors, training of staff and presenting a bid for central CTG monitoring on the labour ward. Although this was identified as completed on the action plan not all actions had been completed. This included the training of staff which was below the trusts target in January 2016.
- Midwives were using a "fresh eyes" approach for the review of CTG monitor recordings as recommended by the Royal College of Midwives.
- Not all parameters for accurate initial and ongoing assessment of patients in labour were used. On the records we reviewed no manual pulse had been recorded. This did not meet with National Institute for Clinical Excellence (NICE) guidance "Intrapartum care for healthy women and babies." which states the midwife "should palpate the maternal pulse to differentiate between maternal and foetal heart rate".
- The World Health Organisations (WHO) 5 steps to safer surgery had been integrated into the perioperative record. However midwives who would be assisting in theatre were unclear about the use of a specific maternity WHO checklist which they understood was to be introduced.
- The WHO briefing documents we reviewed were not fully completed. Examples of missing information included the WHO meeting time not being recorded and one specific issue with a patient documented as "BMI 2nd case" with no further information with regards special equipment or changes to practice. None of the 36 trust wide records we reviewed had the team debrief section completed.
- The system to assess patients in the maternity assessment unit was changed between the first and second weeks of the inspection to ensure patients received a timely risk assessment. This was in response to concerns raised on the first week of the inspection.
- The telephone triage system did not ensure all necessary information was obtained and appropriate advice was always given. There was no record a midwife had checked the information provided if it had been given by a ward clerk or health care assistant.
- The high dependency room on the delivery suite was used for patients who required a greater degree of observation. We saw support was provided from intensive care staff if it was required. Should any patient require intensive care they would be transferred to the critical care unit in the general hospital.
- There could be delays in the transfer of a patient to the labour ward due to staffing levels and capacity constraints.
- The potential risk of infection and the need to obtain the results of diagnostic tests was discussed during shift handover.
- The need for a system to identify and assess risks and have a process of escalation for the maternity services as a whole was identified on the maternity improvement plan. A rounding tool was developed and used four times per day by the manager in charge to assess the risks and the measures needed to reduce them. We raised concerns during the inspection that this was not consistently used and not always implemented effectively. Changes were made to ensure risks were consistently assessed and managed proactively in a timely way.
- The increased risks associated with patients with a high BMI may not be identified or appropriately managed. The patients' body mass index should be recorded at the first "booking" appointment. On the seven records we reviewed this had not been completed for two patients. We saw this had been highlighted as an area of care which needed improvement on two incident reports.

Midwifery staffing

- The numbers of midwives to birth ratio was worse than the England average. Managers were confused about how this had been calculated and a revised ration of 1:31 was provided by the trust on 3 March 2016. The England average was 1:28.

Maternity and gynaecology

- Information provided by the trust showed one to one care in established labour did not meet the 100% of births target between April and October 2015. The lowest was 96.5%.
- "Failure to achieve safe staffing levels" was on the risk register and all the midwives and managers we spoke with stated staffing issues were their major concern for the maternity services.
- Midwife numbers were significantly below those planned on the labour ward. For week commencing 22 February 2016 nine shifts were not staffed to the planned level of eight midwives. On one shift there were four midwives and weekends had six per shift. The frequency of shortages meant these shifts could remain unfilled as staff worked a significant number of hours over those planned.
- The reduced number of midwives on the labour ward was further depleted when midwives assisted in theatre. This had been recognised and an agency "scrub" nurse was employed to work 8pm to 8am. At the unannounced inspection on 17 March 2016 this had been extended to include an agency "scrub" nurse on the days elective caesarean sections were booked. Further action was taken following the inspection.
- Managers on the wards were unsure how their staffing establishment had been calculated and why there were variations. On the labour ward in May 2015 the establishment was 31.2 whole time equivalent midwives and in September 2015 it was 34.9.
- Information provided by the trust showed the unfilled shift rates had improved between November 2015 and January 2016. The labour ward had 88.5% of day shifts filled with midwives in November and this had risen to 95.6% in January.
- On the rota for 7 March to 3 April 2016 there were 204 vacant shifts in the labour ward. Ward staff had the task of filling these shifts by asking bank staff or ward staff to work extra hours, swapping day to night shifts and cancelling other commitments such as training. If they could not be filled this way agency staff would be used.
- Staffing red flags were raised as per NICE safe staffing guidance for incidents such as staff having no breaks. We saw staff who had worked since 7.30am and had no break at 3.45pm. Records showed of 48 staff on the labour ward only eight were not owed time back due to missed breaks. For most this time amounted to one whole shift.
- Any staffing red flag incidents were documented on the rounding tool and should be reported as an incident in accordance with trust policy. Staff told us as it had become the norm to have lower than planned staff numbers and not to have their break they rarely reported incidents. Between 1 December 2014 and 30 November 2014 there were 46 incidents of shortage of staff reported.
- There was a high level of sickness among the midwives. Sickness rates for midwifery staff were 9.89% between 1 February 2015 and 31 January 2016. On the antenatal ward the sickness rate was 9.5% on the week of the inspection and had been 11% the week before. Sickness in the community was four full time midwives.
- The vacancy rate at 31 January 2016 was 3.89%. However there was an absence of 8.4 whole time equivalent staff in the maternity assessment unit and antenatal clinic due to sickness and vacancies. On the antenatal ward the vacancies were 7.5 midwives.
- Information provided by the trust showed the turnover rate was 13.4% between 1 February and 31 January 2016.
- Outside normal working hours the labour ward co-ordinator had multiple roles. They were responsible for the oversight of activity, staffing and safety for all the maternity departments as well as managing labour ward. Due to shortage of midwives they usually worked clinically and stated this meant they often found it difficult to ensure safe working practices were maintained and they were abreast of the quickly changing picture.
- The manager on call for the hospital out of hours could be a nonclinical manager. Midwives told us this made it difficult to explain the situation and the need for consideration of implementing the divert procedure.
- There was an inconsistency of adherence to the escalation policy. In some areas managers on nonclinical duties were "redeployed to support the clinical frontline" as per the policy whilst in other areas they were not.
- There was a lack of consistency in shift handover in two areas of the maternity service. This included varied information provided such as the safety message and discussions about the day's potential activity.

Maternity and gynaecology

- On the maternity assessment unit a twilight shift had been introduced to increase the staff numbers between 8pm and 2am. However the unit still closed most nights as after 2am there was usually only one midwife with one health care assistant.
- The rota for some staff took no account of the need for appropriate rest time or social hours. One example was a band 5 midwife who had worked 17 consecutive weekends and others who finished night shifts on Monday morning at 8am and started day shifts on Tuesday morning at 8am. The staff rota was completed electronically and in some areas there was no management oversight to ensure the result was workable for the individual.
- Community midwives used to have a system of three midwives being on call which provided increased cover if two had to attend a home birth. This was stopped by management; however they were told it was to be reinstated in December but at the time of the inspection it had not occurred.
- To aid continuity if a patient was transferred from the birth centre to the labour ward the midwife would stay with them if possible.
- Post natal ward tried to have four midwives on duty. This was three to take the patients and one to have oversight and coordinate discharges.
- There had been no use of agency staff on the post natal ward in March 2015 with the highest rate in the previous 12 months being 3%. There was no information provided for other areas in the maternity services.
- There were two band 5 nurses in the gynaecology assessment unit and a band 7 manager. They were experienced gynaecology nurses and told us the staffing was adequate for the activity of the unit.
- Information from the trust was that community midwives had approximately 100 patients on their caseloads. This was under review at the time of the inspection.

Medical staffing

- Information from the trust showed that there had been 135 hours of consultant cover on the labour ward to March 2015. In that period there had been 4557 births which meant this amount of consultant cover exceeded the Royal College of Obstetric and Gynaecology guidelines of 98 hours for 4000 to 5000 births. The number of consultant hours had reduced to a low of 113 in the following three months.
- Three consultants and five junior doctors told us they were concerned about gaps in the consultant resident on call rota on Friday evenings, Saturday and Sunday. There was a twilight shift 5pm to 8.30pm from Monday to Thursday; however there was no resident cover for this shift on a Friday which meant there was no resident on call between 5pm Friday and 8am Monday. A consultant was on call from home and two middle grade doctors provided resident cover.
- The maternity unit had 12 posts at consultant level; however nine were filled substantively and three were filled by long term locums. There were six of the consultant who did resident on call hours and they were supported by a consultant on call from home.
- Doctors of various grades told us some consultants who were on call from home over the weekend were reluctant to attend if called for support. An example was given of when support was requested with the delivery of a baby; however the consultant did not attend. This did not meet Royal College of Obstetric and Gynaecology guidance “Responsibility of a consultant on call”. This states the on-call consultant must be available, on the telephone for advice and able to come in when their presence is needed. It should be remembered that ‘needed’ applies to the trainees’ needs, not the consultant’s need”. This concern was raised with the trust and assurance given that all consultants worked within the guidance.
- Medical handovers took place at the change of each shift. The labour ward manager or band 7 co-ordinator attended these if they were able.
- The weekend ward rounds on the maternity unit were not at a set time which meant midwives and doctors could not plan for reviews.
- There was dedicated medical cover in the maternity assessment unit between 8am and 5pm. Outside these hours the doctor on call for the gynaecology services provided support.
- Midwives on the postnatal and antenatal wards told us they could access medical cover during the night from the labour ward or the gynaecology unit. This included a consultant should their input be required.
- There was 24 hour anaesthetic availability in obstetrics. If the second theatre was required due to an emergency a team from the general surgery theatres would attend.
- The consultant on the labour ward provided gynaecology cover to the gynaecology assessment unit.

Maternity and gynaecology

Major incident awareness and training

- Staff we spoke with were not aware of their role in a major incident. They had not received training although some were aware there was a policy on the internal internet.

Are maternity and gynaecology services effective?

Requires improvement

We rated maternity and gynaecology services at North Manchester General Hospital requires improvement because:

There was no consultant with a lead in guideline development. Information collated on the maternity dashboard was not used to inform or improve practice. There were delays in the induction of labour due to staffing and capacity issues. Audits had taken place; however when improvements were required actions had not always been identified and where they had they had not been implemented. The trust had set targets for the outcomes for patients and the performance against these was mixed. Where they were not met staff were unable to tell us what actions were being taken to improve them.

Midwives were not up to date with training for some of the tasks they were completing and there was no assessment of their competence for others. Not all medical staff were up to date with maternity specific training. Staff appraisals were not up to date in most areas of the maternity services. There was no access to emergency gynaecology services seven days per week. The principles of the mental capacity act had not been applied in the case of a serious incident where an assumption of impaired capacity had been made due to behaviours.

However policies and procedures were in line with NICE guidance and were up to date. Pain relief was offered in a timely way. There was good support for infant feeding. There was good multi-disciplinary working.

Evidence-based care and treatment

- The trusts' "Maternity care pathway and operational policy" was an overarching policy for maternity services which had been developed in February 2016. This policy replaced those from the individual units which had been amalgamated into the one trust since 2010. This policy was aimed as a guide to staff in the clinical pathway and day to day working of the maternity services.
- This document provided links to other policies such as the safeguarding and clinical record keeping policies.
- Policies and procedures such as antenatal care and induction of labour were in line with NICE guidance.
- The care pathways of pregnant women with complex needs such as diabetes were in line with NICE guidance.
- There was no specific support for patients with a high body mass index including support to adopt a healthier lifestyle although this was part of the NICE recommendations. There was no specialist antenatal clinic or midwife for this group of patients.
- One consultant had been the maternity guideline lead up until six months ago and undertook an update and audit of the guidelines. Since they ceased this role it had remained unfilled.
- The majority of guidelines we reviewed had been updated except for the standard operating procedure for the management of arterial lines which expired in September 2013. Review dates were documented.
- During induction of labour patients could be delayed due to staffing shortages and not being able to move to the labour ward. Senior medical personnel gave examples of delays which caused patients to be unnecessarily in labour for 24 hours. This did not fit with NICE guidance for intrapartum care. We were told these incidents would be escalated to the senior obstetric managers.
- There was no enhanced recovery pathway following a caesarean section. We were told one was to be developed however work on this had not begun.
- Information was collated on the maternity dashboard such as modes of delivery, post- partum haemorrhage rates and staff training. There was a lot of useful information stored however medical consultants and midwifery managers told us they were unaware how this was used to inform practice.
- The content of the maternity dashboard was discussed at the monthly quality and performance committee meetings. These were trust wide meetings for the womens and children's directorate. On the minutes we saw these discussions concerned the data to be collected and working with other agencies to collate

data and not the outcomes indicated by it. Charts had been developed, in the past four months, to elicit trends from the data. There was no discussion around this in the information we saw.

- At the monthly quality and performance meetings the gynaecology dashboard was discussed including information against targets such as the referral to treatment and cancer wait times.
- Audits of specific maternity activity had taken place. This included the "Labour and birth" audit which was published in January 2015 from data collected January to December 2013. In this audit practice was compared against trust guidelines which were based on NICE guidance. Actions were identified to be discussed with staff at handover through a "lessons of the week" newsletter. We saw one of the actions was to continue risk assessments at handover of care. This had been identified as one of the actions not completed and contributing to the outcome of a serious incident in October 2015. Therefore whilst this audit had been comprehensive in nature the outcome and identified actions were not embedded in practice 10 months later.
- An audit of the EWS had taken place in May 2015. This had been conducted as a result of the external review of maternity services. This highlighted "a failure by midwifery and obstetric staff to follow clinical guidelines relating to standards for patient observations including the track and trigger system of physiological observation reporting". One of the recommendations which resulted from this audit was "further audit should be undertaken monthly by the Ward Managers in all areas to ensure standards for physiological observations are maintained". None of the ward managers we spoke with had conducted any audits into the completion of EWS on their wards. This audit had not been repeated. We found EWS had not been accurately completed.
- We saw antenatal records were not fully completed such as body mass index and risk assessments not recorded. There were no audits in place to identify these shortfalls or take actions to address them.
- The anaesthetic department had an ongoing audit programme which included record keeping and use of the surgical safety checklist.
- An audit of the anaesthetist response times for Category one and two (emergency) caesarean sections had been completed in 2014. The outcome was "we failed to meet the audit target of more than 90% of our caesarean deliveries being either less than 30 minutes for category 1 at 85% and less than 75 minutes for category 2 at 80%." Despite there being six recommendations there was no action plan developed to improve the outcome. This audit had not been repeated.

Pain relief

- Midwives discussed during handover the pain relief provided to patients, its effectiveness and the need to offer further pain relief where appropriate.
- A patient's level of pain was assessed. There was a pain score on the early warning score record and the seven we reviewed had been completed.
- Patients were offered a variety of pain relief including oral, medical gas and epidural analgesia.
- Patients told us they had pain relief administered when they requested and without delay.
- The anaesthetist support meant a doctor was available to administer epidural pain relief within 30 minutes of request which met NICE guidance.
- Community midwives had access to pain relief including gas and air (Entonox) for home births.

Nutrition and hydration

- The trust had been awarded stage 3 Baby friendly accreditation. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. This was due for reassessment.
- There was an infant feeding co-ordinator who worked 8am to 4pm Monday to Friday across the trust and a support worker who worked 9.30am to 5.15pm three days per week. There were also three volunteers who supported new mothers seven days per week. This support included those experiencing difficulties feeding their babies, mothers with babies on the special care baby unit who needed to express their milk and any other infant feeding issues which occurred.
- The infant feeding team would offer advice over the telephone if required once a patient had returned home.
- A tongue tie clinic was held and the infant feeding support workers could refer patients to that clinic. There was a three week waiting list for this clinic which could mean babies had difficulties feeding throughout that time.

- We saw staff gave food and drinks to waiting patients in the maternity assessment unit.
- We observed that specific dietary needs were met by the food provided in the hospital such as Kosher, halal food and gluten free.
- A face to face survey of patients on the post natal ward resulted in mainly positive comments about the food and drink provision. These ranged from "great tea and toast" from six patients to "good choice". The negative comments included "poor choice – poor quality" and not being offered food and drink for a considerable time.
- There was limited provision for food and drink in the gynaecology assessment unit with a vending machine and facility for patients to bring in their own food.

Patient outcomes

- The process for completing elective caesarean sections had been changed so that there was an operating list all day on Monday and Thursday to accommodate them. This made it easier to plan for adequate staff numbers on those days and there were no cancellations recorded.
- The normal delivery rate target of 65% had been met for six of nine months April to December 2015.
- The elective caesarean section rate of less than 10% of total births had been met in four of the nine months April to December 2015. In two of these months it had been flagged as a high risk at 11.3% and 12.6%.
- The emergency caesarean section rate was higher than the trusts' target. It had been in the high risk category on five occasions with the highest being 18.3%. It had been below the target of less than 15% of total births in two of the nine months.
- Inductions of labour were over the trusts' target of less than 27% of total births in eight of the nine months reported on the dashboard. These had decreased from 32.1% in April 2015 to 26.5% in December
- Staff reported delays in meeting the National standard of a patients' first booking appointment by 12+6 week. The trust were unable to provide figures since most bookings were done at home. Reasons for this had been discussed at the monthly quality and performance meetings and actions to address it were to be identified.
- The total number of stillbirths was lower than the target of less than 4 per 1000 in eight of the nine months.
- The incidence of patients having skin to skin contact following the birth of their baby was below the 75% target every month. Midwives told us they were aware of this but there was no specific action plan in place to improve this outcome.
- Maternal admissions to intensive care met the trusts' target for seven out of nine months.
- Patients who had a post-partum haemorrhage of greater than 1000mls was below the trusts' target of 10% for all nine months.
- Two of the three relevant standards from the national neonatal audit programme 2014 were not met. Not all eligible babies had their temperature taken within an hour of birth or were receiving retinopathy screening within the required timescale.

Competent staff

- 94.8% of midwifery staff and 62% of medical staff were up to date with PROMPT (PRractical Obstetric Multi Professional Training) as of October 2015. Basic life support and neonatal resuscitation were included in this training. The medical staff did not meet the trusts' target of 95%. As part of the maternity improvement plan an audit of PROMPT training and addition to the mandatory training had been completed. An additional action of reviewing the content of the course had been added; however there was no action to ensure all staff were up to date. Failure to meet this target was on the service risk register as there was recognition that high sickness and absence reduced attendance.
- Midwives worked in theatre as "scrub" nurses and to recover the patient and baby following a caesarean section. Some midwives had been trained in the main theatres during their initial training; however this had ceased and been replaced by observation of a midwife carrying out these duties then completed it themselves under that midwives supervision. This does not meet with the Association of anaesthetists of Great Britain and Ireland Guidance 2013.
- There was no competence assessment or refresher training for midwives who had completed their "scrub" training many years ago. One midwife had completed this training 26 years ago and never had a competence assessment or refresher training. They had been responsible for training other midwives.

- One midwife told us there had been a gap of 14 months between them completing a new-born initial physical examination. During that time there was no update training or competence assessment which meant their skills to complete this may not be up to date.
- The ratio of supervisors of midwives to midwives was 1:15 which met the required standard.
- In June 2015 the local supervisor of midwives audit report highlighted that less than 80% of supervisors of midwives were up to date with their post registration education and practice standards activities. This did not meet the required standard.
- Some supervisors of midwives had relinquished this post due to an inability to fulfil the role adequately. The requirement for 80% attendance of supervisors of midwives at team meetings had not been met at the last audit.
- The appraisal rates for April to November 2015 were 64.21% for nursing and midwifery staff in the general maternity unit. They were 42.86% for staff on the birth centre and 40% for community midwives. This meant staff were not up to date with the appraisal of their performance.
- Trainee doctors had a two day induction when they started at the hospital. They described this as "very comprehensive".
- Trainee doctors told us they had protected time to attend scheduled training and had the support they required with this.
- Two midwives had resigned as supervisors of midwives due to a lack of time, recognition and support from senior management to complete their role.

Multidisciplinary working

- Medical and midwifery staff described good team working between them. We saw them communicate with each other in a professional, polite and friendly manner.
- Multidisciplinary clinics for the care of patients with diabetes took place. This included a diabetic specialist midwife and doctor.
- There were meetings four times annually with screening midwives, doctors and the laboratories where diagnostic tests were processed. At these meetings the management of the screening programme any concerns and changes to the tests carried out were discussed.
- Meetings took place with the screening midwives obstetricians and neonatologists to discuss the introduction of Newborn and infant physical examination, screening management and reporting tool (NIPE smart) which would improve the quality, timeliness and consistency of the examinations.
- Public health team meetings took place every six to eight weeks. The public health midwives such as the teenage pregnancy support midwives and the screening midwives attended these meetings.
- There was no multi-disciplinary handover on the labour ward. This should have been introduced as part of the maternity improvement plan; however the manager told us the absence of midwifery input was historic and they had been unable to make changes.
- There was integrated working with the neonatal and anaesthetic teams when a patient attending for an elective caesarean section had known complications. The matron reviewed the operating list the week before and communicated with the necessary doctors.
- Staff described good communication with the community maternity team, especially in the antenatal period or where there were complex health or social issues.

Seven-day services

- Maternity triage facilities were available 24 hours per day seven days per week.
- The ante-natal day unit was open 9am to 5pm Monday to Friday. Between those times if patients required treatment which could not wait, such as urgent blood tests, they would attend the antenatal ward or triage area.
- The gynaecology assessment unit was open from 7.30am to 9pm seven days per week. Outside of these hours patients were seen in the accident and emergency department or would be redirected to Royal Oldham Hospital where there was 24 hour provision.
- There was a 24 hour seven days per week emergency scanning facility if required.

Access to information

- Staff in ante-natal clinics and the day assessment unit told us records for patients were available for their appointment.
- There were some records currently being duplicated as an electronic system of record keeping was introduced. This increased the time it took to record some care interventions and for staff to locate some records as they were becoming familiar with the new systems.

- There were information screens which could be used to record and display information such as bed occupancy. The user could access the information from other parts of the maternity units for example from labour ward to see if there were vacant beds on the post natal ward. Not all staff were using these screens and they were unsure if they could be used to store more information which could be useful in managing the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The consent forms were pre-printed with an agreed list of potential complications and boxes to tick as appropriate.
- We reviewed three consent forms for emergency procedures. On one the section to indicate what was involved in the procedure was not ticked and the doctors' signature was unreadable.
- For one patient who did not speak English as their first language an interpreter had been present to obtain consent. This was documented in the notes, but there was no detail recorded for example how the choice of a general or a regional anaesthetic had been made.
- Staff were aware of the mental capacity act; however we saw that in one of the serious incidents midwives had made an assumption of impaired mental capacity due to behaviours displayed with no application of assessment in line with the Act.

Are maternity and gynaecology services caring?

Good

We rated maternity and gynaecology services at North Manchester General Hospital good for caring because:

We observed midwives to be respectful, caring and kind to patients and their families. They were calm and reassuring even in difficult situations. They made sure they gave advice and support in a way the patient would understand and listened to them and their concerns. They protected patients' privacy and dignity. Patients and relatives were complimentary about staff and the care they had received. The trust scored the same as the England average in the friends and family test and in line with other trusts in the CQC maternity survey.

Patients and their partners were involved in their maternity care and partners were able to stay on the post natal ward. Choices were discussed such as opting for midwifery or consultant led care and discussions took place if changes occurred which meant these options were no longer available. Emotional support was available for patients who had additional support needs or had bereavement.

Compassionate care

- Midwives were concerned the busy workload meant they could not provide the quality of care they would like. They told us they felt rushed to leave a patient too quickly after their birth and could not provide the additional support and advice some patient's may need.
- Patients we spoke with told us the staff were very kind and caring, but had recognised they were very busy.
- We heard staff speaking to patients in a kind and caring way both face to face and over the telephone. They listened to the patients and gave clear explanations when offering support and advice.
- When staff spoke about patients for example during shift handover they did so in a dignified and respectful way.
- Volunteers had carried out face to face interviews with 44 patients on the post natal ward in September and November 2015. The questions were around the quality of the care provided and most responses were positive. Comments included "staff lovely" "everyone brilliant" and "can't fault them".
- The trust performed in line with or above the England average for percentage recommend for three of the four areas of the friends and family test between July 2014 and October 2015.
- The trust scored about the same as others for all 17 questions in the CQC maternity survey 2015.
- Midwives were concerned that the privacy and dignity of patients could be compromised if they needed to transport them along the main public corridor to the labour ward from the maternity assessment unit when they were in labour. They discussed how they did this as quickly as possible but it was a concern which they had raised with the trust.

Understanding and involvement of patients and those close to them

- Patients told us they had been involved in decisions about where to have their baby and whether to opt for midwifery led care, homebirth or consultant led care.

- Through discussions with staff we saw they had a good understanding of the need for patients to have their partners or birth supporter with them. They understood if there was a specific additional need for this for example a young patient.
- We observed staff including partners in the care they were providing for the patient and the new-born baby. Partners we spoke with said they had felt involved and supported.
- There was open visiting for partners on the post natal ward. Whilst this was not without its issues of additional noise and increased people in the environment patients appreciated it.
- We saw that where a patient may need additional emotional support from a family member this was accommodated, including in the antenatal period and overnight.

Emotional support

- We saw during shift handover on the antenatal ward that the emotional support required by patients was discussed in a sensitive manner. This included anxieties due to difficulties in previous pregnancies.
- The bereavement midwife offered support and advice to patients who had suffered a loss. They were accessible by telephone as well as face to face in the trust.
- Midwives attended a bereavement study day once every two years to help them better support any bereaved patients.
- An obstetric consultant held a clinic for follow up care to patients whose baby had been stillborn.
- Coffee mornings were held for patients who had been bereaved. They could attend and offer support to each other facilitated by the bereavement midwife.
- There were arrangements to ensure the privacy of patients who had a miscarriage. This included provision of private rooms on the gynaecology assessment unit and sensitive offering of support and aftercare.
- At the first "booking" appointment the mental health of a patient was discussed and written information provided regarding their emotional wellbeing throughout the pregnancy was given.
- There was a specialist midwife who provided additional support for those patients with mental health problems.
- Midwives had information to provide to patients to signpost them to additional support services if these were required.

Are maternity and gynaecology services responsive?

Requires improvement

We rated maternity and gynaecology services at North Manchester General Hospital requires improvement for responsive because:

Patients had to be diverted to alternative maternity units due to shortage of staff and a lack of capacity. There was a lack of gynaecology assessment out of hours and no inpatient gynaecology service at this trust site. There was no specialist foetal medicine service which meant patients had to travel to access this at another trust. The location of the maternity assessment unit was unclear for returning patients due to it being relocated most nights due to staff shortages. There were delays in transfer to the labour ward and concerns about the privacy of patients being transferred in public corridors whilst in labour. The average length of stay was longer than the trusts' target. There was no system across the service for sharing lessons learnt from complaints.

However there was good access to scanning facilities including out of normal working hours. There were processes in place to facilitate timely discharge from the maternity assessment unit. The bed occupancy was lower than the England average. There was a good system of discharging patients from the post natal ward which reduced delays.

Service planning and delivery to meet the needs of local people

- There was no area designated for rapid rehydration for patients with hyperemesis. They had to attend the female surgical ward which midwives thought was not the best environment for them due to the needs of the other patients in that area. There were plans to provide an area for this procedure in the maternity assessment unit.
- There was no foetal medicine service at the hospital. This had been provided previously however when the lead consultant was no longer at the hospital the post had not been filled. Medical staff felt for the number and complexity of the patients they saw this was a gap in local provision.

- There was always access to medical review for patients whose scans showed a foetal anomaly.
- The gynaecology assessment unit was not open between 9pm and 7.30am. The unit at Royal Oldham hospital was open 24 hours per day and patients would be redirected there. Although patients who had attended the unit at this site were told to go to Royal Oldham out of hours there was no mechanism for sharing of clinical information between the two sites.
- Three emergency gynaecology beds at this site had closed which meant there was no inpatient gynaecology provision. This meant patients had to be transferred to Royal Oldham Hospital in an emergency.
- Patients who attended the gynaecology assessment unit could access a scan within 24 hours and the sonographers worked flexibly to meet the needs of patients.

Access and flow

- Information from the trust showed the patients had been diverted to an alternative maternity unit on five occasions between January and December 2015. However staff told us there had been an increase in this since then including the week of our inspection. The trust did not provide this up to date information.
- The maternity assessment unit provided open access for patients who were 16 weeks pregnant and above. Patients could self -refer if they had concerns, or be referred by their GP or the emergency department.
- The maternity assessment unit was relocated to the antenatal ward most nights due to only one midwife and one health care assistant being present in the unit. This had occurred 14 times in January 2016 and 12 in February 2016. For week commencing the 7th March 2016 there was one midwife on the rota every night.
- Despite signage being displayed that this unit had moved we observed patients who were returning following earlier visits arriving at the wrong site when in labour and being redirected to find their way to the correct place without staff assistance.
- When this move occurred staff had to take necessary equipment to the antenatal ward to ensure they could provide necessary care and support.
- The arrival and departure times for patients in the maternity assessment unit were documented. However this information was not used to assess the length of waiting times or make improvements.
- There were plans to create an area where patients in the maternity assessment unit could have their blood tests taken which would mean they would not need to occupy an assessment room to have this completed.
- Midwives could discharge patients from the maternity assessment unit without medical review. This meant there were no delays in discharge from this area.
- Urgent transfers from the maternity assessment ward to the labour suite or obstetric theatres was via public corridors and lifts. Staff said when this occurred they could move quickly; however they were concerned for the privacy and dignity of a labouring woman during this journey.
- Due to capacity and staff shortages on the labour ward we saw delays in transfers from the antenatal ward or maternity assessment unit did occur. Between January and November 2015 there had been 10 births in areas of the maternity unit other than the labour ward. There was no record of emergencies transfers following delay.
- The average length of stay for patients following delivery was 2.5 days between April and December 2015. For those who had been admitted for reasons other than to deliver their baby the average stay was 2.2 days. This was over the trusts' target of 1.5 days. Those who delivered in the birth centre were within the trusts' target.
- We observed that whilst there were good systems for discharge from the post natal ward patients stayed for prolonged periods if they requested this. Examples we observed were for patients to gain confidence before going home or improve feeding of their baby.
- Bed occupancy rates were lower than the England average.
- The system for inductions of labour had been reviewed to improve the access for patients. Five inductions per day were planned and the admissions of these patients were staggered throughout the day, prioritised by risk. This meant not all patients labour was progressing at the same stage.
- There were delays in inductions of labour due to lack of availability of midwives. When patients had begun the induction process and were assessed as being ready for an artificial rupture of their membranes this could be delayed if there were insufficient midwives or capacity on the labour ward for the patient to be moved when appropriate. We saw nine patients waiting for their inductions to be progressed and were told at least three

had waited beyond two hours which had been raised as a staffing red flag incident. Midwives told us this was common and the previous week two patients had waited 30 hours.
- On the post natal wards nursery nurses were employed who were trained to complete the new-born initial physical examination checks. This reduced the need for patients to wait for paediatricians and assisted in a more timely discharge.
- There had been changes to staff deployment on the post natal ward which had resulted in more timely discharges and reduced the need for post natal patients to be accommodated on the antenatal ward. A band 3 healthcare assistant worked as a discharge co-ordinator and one band 6 midwife was the shift leader. This meant the work was well co-ordinated, oversight of activity was provided and a designated staff member liaised with other professionals for safe discharges, such as social services.
- When staff from the postnatal ward were redeployed this could cause delays in discharge.
- Staff reported medical review for discharge was usually quickly available and did not cause delays.
- Although midwives could be used from the midwifery led birth centre during busy periods the area had closed only once in four years at the time of our announced inspection. At the unannounced inspection this had occurred again as a result of a review of the escalation policy.
- To aid the patient flow if a low risk patient was on the maternity assessment unit and in labour with no bed available on the labour ward they would be offered the opportunity to give birth in the birth centre if a bed was available, even if that had not been the intention.
- Patients could access the gynaecology assessment unit if they were referred by their GP or midwife if the problems were in early pregnancy. They could not self-refer to this unit.

Meeting people's individual needs

- An induction of labour timeline was given to patients as a communication tool for them to understand the sequence of care interventions which would take place. We saw this to be in use.
- All written information and patient leaflets were in English. There was a large proportion of the patients for whom English was not their first language. Staff said they could obtain leaflets in other languages; however there could be a delay in obtaining these.
- There was easy and quick access to translation services which included face to face translation when required. The midwives and doctors we spoke with understood the need for face to face translation with the majority of their patients to ensure a clear understanding of complex information. We saw some good examples of the use of translation services such as to gain consent for surgical procedures and discuss anomalies on a scan. However it was not always used when a need was identified for example during antenatal appointments even though difficulties of speaking English had been recorded.
- There was limited support from the bereavement midwife due to them having only 15 hours per week allocated to this aspect of their work.
- There could be delays in obtaining the required medical consent for a termination of pregnancy following confirmation of a foetal anomaly. There was no procedure for access to a doctor who would sign and no list for midwives to know which doctors would sign the consent forms.
- The public health team consisted of ten specialist midwives. This included mental health midwives, drug and alcohol and teenage pregnancy midwives. These specialists met the needs of patients with complex needs.

Learning from complaints and concerns

- Between 1 December 2015 and 31 December 2015 there were 29 complaints for maternity and gynaecology services. This represented 35% of the total for these services trust wide. The majority of these were about clinical care and treatment.
- Trust wide information showed that on average it took the service 139 days to close a complaint.
- Complaints were discussed at the women's and children's quality and performance committee meetings. We saw discussions included the numbers of new complaints, any themes and issues such as meeting timescales for responses.
- There was no consistent process for staff receiving feedback from lessons learnt from complaints. In some areas they told us they had this if they had been

involved and in others that they did not get any feedback. In the meeting minutes of October 2015 it was documented that "clear lessons learnt need to be documented explaining what was done and how we changed things". For one complaint which included a serious concern the actions taken to prevent recurrence were documented.

- There was an example of a change in practice following a complaint in the maternity assessment unit. As the result of a patient giving birth before arrival at the unit the information required from another professional over the phone had been made more comprehensive.
- Information about how to make a complaint was displayed in the maternity services. This was in English and leaflets would have to be requested in another language. This meant people for whom English was not their first language may not understand how to complain.

Are maternity and gynaecology services well-led?

Inadequate

We rated maternity and gynaecology services at North Manchester General Hospital Inadeqaute for being well led because:

- Staff were unclear about the vision for this service. There had been a focus on the maternity improvement plan which was developed following the external review in January 2015; however there was no strategy for continuous improvement or sustaining the changes which had been implemented.
- There was a lack of clear systems and processes for managing risks and performance of the service. Those staff with this responsibility had a lack of protected time to fulfil this role.
- The systems for investigating incidents resulted in delays and a lack of learning and improvement.
- There was a lack of visible midwifery leadership above ward level
- There was low morale and a culture of blame in midwifery services.
- There were concerns from staff regarding a lack of openness with patients when things went wrong; however they said this was improving.
- Staff of all grades had not been involved in the development of the maternity improvement plan.
- There were few mechanisms for staff engagement and plans to improve this had not taken place. Some improvements in public engagement had occurred; however plans for others had been postponed. There was little encouragement for innovation from staff.

However

- Medical staff were well supported and midwives were enthusiastic to be part of an improving service.
- There were changes in the leadership of the service following our inspection. Between the announced and unannounced inspection some practical changes had been made and staff told us there was already an improvement in communication.

Vision and strategy for this service

- Midwifery, nursing and medical staff we spoke with were unclear about the vision for this service. This included service managers and clinical leads.
- The focus had been on the maternity improvement plan which was originally developed as a result of the external review in January 2015. In order to implement this plan interim posts had been developed and there had been management and system changes.
- The focus was on improving the quality of the service provided; however there had been no clear overarching strategy to deliver this and provide oversight to the 201 separate actions which had been completed as part of this plan.
- There was no strategy for the continuous improvement of the service including how changes as a result of the improvement plan would be sustained.

Governance, risk management and quality measurement

- The maternity improvement plan was overseen within the trust by the gold meeting which was chaired by the chief nurse and medical director and incident management group jointly chaired by the chief nurse and CCG chair. There was also project management support provided by the trust internal patient safety team. This was audited to provide further assurance to the management group.

Maternity and gynaecology

- Governance of the maternity and gynaecology services was led by the women and children's directorate triumvirate. Senior staff were unclear how this worked in terms of their role in the management of the performance of the service.
- Changes to the governance processes had been put into place since the external review and a looking back through previous incidents exercise. This included senior staff meeting on a weekly then monthly basis to discuss the necessary changes to improve the service; an incident management group being set up and smaller working parties to implement change. However there was a lack of clarity among staff about the systems and processes for governance of the service.
- The mechanisms in place to measure the performance of the service were unclear to senior staff. Band 7 and 8 midwives and medical staff told us the maternity dashboard was used as an information collection point. They had not been informed how the data would be interpreted to provide a measure of the quality of the service. They thought this was early days in the development of this tool and hoped the information would be used to inform practices and make improvements in the future.
- Managers in some areas told us they did not have the protected time they required to ensure they could complete their management duties. They should have one day per week allocated; however this was not protected from clinical work due to low staffing numbers.
- There was a risk register for the maternity and gynaecology service. This had 11 risks documented with four being high risk. Controls, gaps and actions were recorded with target dates. Two of the risks were dated 2013 with the remaining nine dated between 15 December and 21 December 2015.
- The failure to achieve safe staffing levels was on the risk register and some ward managers had completed risk assessments for reduced staffing numbers in their area. However they had not received feedback about remedial action being taken whilst longer term recruitment was underway.
- The clinical director had one day to complete the duties required to provide clinical oversight to the unit. They stated with the improvement work required this was inadequate.
- There was a lack of time for the consultants with the lead role in risk management and governance to complete the associated duties. They had three hours per week allocated in their job plan to carry out this work and told us they carried out many tasks in their own time.
- Ward accreditation was being introduced and most areas in the maternity services were preparing for this.

Leadership of service

- Midwives told us they saw the midwifery lead "never", "rarely" and "occasionally" on the wards and departments. Although they reported having seen other leaders in the service more frequently.
- Band 7 and 8 midwives told us they had good support from the trust which included visible line managers and an open door policy to discuss issues.
- Midwives reported a lack of communication from the top down. They stated there were no working mechanisms for clear communication and some historical barriers to communication which most ward managers were working to eradicate.
- There was a leadership programme for band 7 and 8 midwives. They were supported by the trust to complete this training over one year.
- Obstetric and gynaecology medical staff told us they could approach their managers and clinical leaders for the service. They said they would get support and advice when needed from senior medical personnel.
- Human resources issues were not managed in a timely way to ensure the right people were in the right job. Senior medical staff discussed some concerns regarding the employment of seven locum consultants where integration into the substantive team, or their replacement with permanent staff had not progressed for four years.
- There were examples of good ward leadership where staff were being supported to develop skills and systems were put in place for increased engagement. These were in their infancy and as such had not yet yielded the expected benefits.

Culture within the service

- Staff of all grades told us morale in the maternity services was low. The key reasons for this were cited as a lack of communication about the future of services and no positive reinforcement from trust management for the service they provided.

- Failure to improve staff morale across maternity services in the trust was on the risk register since 2013. The documented gaps in the control for this risk were "lack of consistent communication, lack of senior management visibility and lack of feedback". There were three actions to address this which included a staff engagement programme and back to the floor implementation. This was due for review in March 2016. During our inspection no staff we spoke with were aware of any of these measures being in place.
- At the time of the announced inspection staff of all grades spoke of a blame culture particularly where incident reporting was concerned. At the unannounced inspection we were told "things were improving" and they felt more encouraged that this culture would change.
- There were some concerns amongst senior staff that the lack of openness affected the duty of candour shown to patients when things went wrong. We saw documentation about incidents where it was unclear if the duty of candour had been followed at the time of the incident.

Public engagement

- The inaugural meeting of the new maternity services liaison committee hosted by Pennine Acute Trust (PAT) to cover the PAT geographical area took place on 14 October 2015. A name change from Maternity Services Liaison Committee to Maternity Listening and Action Group was agreed along with forthcoming dates for the bimonthly meetings. It was agreed the most important element was for patients to discuss their experiences so lessons could be learned.
- Midwives had developed a method of feedback for patients on the labour ward. They had surveyed 50 patients and 86% stated they would definitely recommend the unit to other pregnant women.
- Public engagement sessions were to take place as part of the maternity improvement plan. The planning of these was discussed 12 August 2015. On 9 September it was documented that the next step was to arrange community locality meetings to include Healthwatch. This had not taken place at the time of our inspection.

Staff engagement

- Medical staff and midwives of all grades including managers told us there had been no feedback following the external review of maternity services and they had not been consulted during the development of the maternity improvement plan. They did now attend the weekly improvement meetings when they were able but these had begun after the initial plan had been developed.
- The weekly improvement plan meetings were open to staff of all grades. Those who attended told us they were a "safe" place to discuss issues and found them useful. The meeting place was alternated between this hospital site and Royal Oldham hospital to allow for easy access for staff.
- Ward meetings were planned monthly; however staff told us it was difficult to attend due to shortage of staff on the clinical areas.
- From the weekly meetings a "3 key messages" poster was developed. We saw this to be displayed in some areas of the maternity services but not all.
- There were weekly matron's meetings where those from all areas of the maternity service met to discuss developments, concerns and ideas.
- Several consultants told us there had been no regular consultant meetings since June 2015. They were unsure why these had ceased and what the plan was for the future. They described limited engagement in the overall strategy and direction of the unit.
- No junior doctors were involved in any local unit meetings either as an observer or participant.
- The first "Pride in maternity staff bulletin" was issued 3 August 2015. This was designed to keep staff abreast of the progress being made with the maternity improvement plan and service developments. Minutes from the maternity gold meeting on 21 October 2015 stated "second maternity bulletin a month late." This showed a lack of commitment to the implementation of this staff engagement vehicle.
- A staff event had been planned for 4 November 2015; however this was cancelled and had not been rearranged at the time of our inspection. This was to be open to all as a "pride in maternity" event.

Innovation, improvement and sustainability

- One of the initiatives to aid improvement was to link with the maternity services at Newcastle upon Tyne hospital. However we found only two staff members who had visited their services or had any consultation with them. We were told further joint visits were planned.

Maternity and gynaecology

- Midwives and managers were enthusiastic to introduce new ways of working and had ideas for change; however due to the shortage of staff the day to day work took precedent and there was a lack of time and no system in place for them to develop the service.
- One of the positive improvements staff had seen was the leadership being more clinically led than previously.
- There were limited opportunities in some areas for staff to develop additional skills which would improve the service. This included no nurses trained to scan on the gynaecology assessment unit.

Senior and clinical managers were concerned that the improvements made with the maternity improvement plan were not sustainable as there were no systems for continuous improvement.

Services for children and young people

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

Information about the service

Pennine Acute NHS Trust offer children and young people services at all four hospital sites. This report will cover the services provided at North Manchester General Hospital.

At North Manchester Hospital, the trust provides a 19-cot neonatal unit based on the ground floor of the Women's unit. The neonatal unit is a designated level two unit (local neonatal unit). These units provide special care and high dependency care and a restricted number of intensive care cots (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit. The neonatal unit has a link tertiary unit at St Mary's hospital in Manchester. Within the unit, there are two level three cots, two level two cots and fifteen level one cots. There are two additional transitional care bedrooms. The neonatal unit operates as part of a regional neonatal managed clinical network to ensure best outcomes for babies.

Most other services for children and young people under 16 are provided from the paediatric ward and in the Koala unit. The ward consists of 27 inpatient beds, one of which is a stabilisation bed which is managed as a HDU bed. The beds are laid out in nine individual cubicles and four bays (three with four beds and one with five beds).

The Koala unit has a waiting room and a separate observation and assessment area with six trolleys. One of the assessment trolleys is in a side room within the assessment area. The paediatric ward has a playroom, a sensory room and a teenager's room. The unit is open from 9:00 – 00:00 but is closed to admissions from 22:00. This unit accepts referrals from GPs, A&E, Health Visitors and Community Nursing teams. Children aged 16 or over, unless a paediatrician knows them, are seen within the main hospital by adult services.

At North Manchester General Hospital Children's surgery is performed from the paediatric unit. From July 2014 to July 2015, there were 8337 admissions to services for children and young people. 7463 of these admissions were emergency admissions, 275 were day case admissions and 599 were elective admissions.

As part of our inspection between 23 February to 26 February, we visited inpatient and outpatient areas, paediatric A&E, paediatric surgery services, the paediatric assessment area and neonatal unit. We spoke with a range of staff providing care and treatment in children and young people's services including: thirteen nurses, four trainee doctors, two consultants, three health care assistants, one ward clerk, two play specialists, a domestic and senior managers.

We talked with eight parents on the ward areas. We observed patient care, talked with carers and reviewed 22 children' records of personal care and treatment.

Services for children and young people

We reviewed comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the hospital. We also requested information prior to, during and after our inspection.

Summary of findings

We found that overall children's services at North Manchester General Hospital were inadequate in terms of being safe and being well led. We found the services requires improvement in terms of being effective, caring and responsive.

Patient safety was a significant concern because:

· Risks were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate them in the longer term.

· There was a failure to effectively investigate and learn from incidents and complaints. There were unacceptable delays in investigations including those resulting in severe harm.

· There was a lack of accurate record keeping which impacted on the services capability to evidence their assessment and responsiveness to patient risk.

· There were few mechanisms for staff engagement and plans to improve this had not taken place.

· We found that the care and treatment delivered did not always reflect current evidence-based guidance, standards and best practice.

· There were gaps in management, supervision and support arrangements for staff. Children received care from insufficient number of staff that did not have refreshed skills or experience that is needed to deliver effective care.

· We found that the needs of the local population were not fully understood when planning this service particularly when considering the number of under two's that would access the children's wards.

· Some people were not able to access services for treatment when they need to.

· There was significant concern regarding how well led the paediatric service was. The delivery of high quality care was not assured by the leadership, governance or culture in place.

However

Services for children and young people

· On the neonatal unit staff interactions were positive and babies were treated with kindness and compassion.

· Parents felt supported and involved in the planning and decisions regarding their child's healthcare.

· Children were positive about their interactions with staff. People's social needs were understood.

Are services for children and young people safe?

Inadequate

Overall, in terms of being safe, we judged that the neonatal and paediatric services at North Manchester General Hospital were inadequate.

Main concerns centred around learning from and investigation of serious incidents, incident reporting, nurse staffing in paediatrics, infection control, safety of equipment, assessment and responsiveness to patient risk, records management and safeguarding. We were not assured that patient safety was a sufficient priority because:

- There were unacceptable delays in the investigation of serious incidents. Learning from incidents was not effectively shared resulting in serious incidents with similar causal factors recurring. This meant the service did not evidence that appropriate actions had been taken to ensure patient safety.
- The trust board relied on incident reporting as an assurance mechanism regarding patient safety. However, nursing staff told us that incidents were not always reported and we observed this on our inspection. Senior nursing staff were aware that staff did not report all incidents. The trust board could not safely rely on incident reporting as a patient safety assurance mechanism because all incidents were not reported.
- Nurse staffing levels and skills mix in paediatrics did not reflect Royal College of Nursing (RCN) guidance (August 2013). In neonatal the levels and skills did not meet British Association of Perinatal Medicine (BAPM) guidance.
- The number of medical and nursing staff that had completed their essential job related training was very low and this risk was not recorded on any of the trust's risk registers.
- During our inspection, we found several infection control risks on the paediatric unit. The risks were escalated to the trust at the time of our inspection.
- Hospital trusts have a legal obligation to ensure that electrical equipment that has the potential to cause

injury is maintained in a safe condition. During our inspection we found approximately 50% of equipment that did not show evidence of current Portable Appliance Testing (PAT). The trust's electrical equipment maintenance log also showed over 50% of equipment was out of date for its routine maintenance, which is a breach of the Electricity at Work Regulations 1989 and the trust's policy.

- Assessments to identify patient's clinical risks had not been completed in line with the trust's policy. Records for the monitoring of children, including neonates, to detect deterioration in their condition were not accurately completed. There was inconsistency in the escalation of children for medical review.
- The intercollegiate document on safeguarding recommends that all clinical staff working with children, young people and/or their parents/carers should be level three trained. At Pennine Acute 72% of paediatric nursing staff had completed level three safeguarding training and 30% of neonatal staff had completed this training.

However;

- At the time of our inspection the ward areas were visibly clean.
- Staff used and encouraged children to use hand gel.
- Staff were also aware of the major incident policy.

During and shortly after our inspection we escalated our concerns to the trust who took immediate steps to address them.

Incidents

Serious Incidents

- There was a disparity in data provided from the trust regarding the number of reported Strategic Executive Information System (Steis) serious incidents. The trust told us that four serious incidents were reported between 7 February 2015 – 28 February 2016. However, during the inspection it was determined that during the same period there had actually been seven serious incidents.The Trust's system for collating STEIS information did not collate all serious incidents.We requested the investigation records (root cause analysis) for these incidents and evidence of lessons that had been learnt. Two of these incidents were reported under old criteria for Steis incidents and were appropriately investigated by A&E. There was one Steis incident in neonatal and a further four Steis incidents in paediatrics. The neonatal incident was investigated and reviewed by maternity in view of the care provided to the patient's mother. The four remaining Steis incidents were paediatric incidents.
- Two of the four paediatric incidents had been reported retrospectively as a result of patient complaints. The need to report and investigate these incidents had not been identified at the time. The investigations and notifications to Steis were delayed by several months (7 months and 3 months). However, we spoke with over 30 members of staff and they were all aware of the trust's electronic reporting system.
- We reviewed two available root cause analyses for the paediatric cases. There were lengthy delays in the investigations and lessons learnt were not shared in a prompt manner. We found no evidence that immediate actions to mitigate ongoing risks were implemented. Learning from incidents was not shared for several months and was via a meeting that was only attended by medical staff, despite nursing issues being identified as some of the causal factors.
- When asked, nursing staff at ward level stated they were unaware of the learning from serious incidents. We looked at quality and performance minutes. Ward meeting minutes were requested but were not provided.
- Across the trust serious incidents with similar contributory causes had recurred in the period between the first incident and learning/actions to prevent recurrence being shared.
- During our inspection we discussed preliminary findings of serious incidents that have occurred more recently but the RCA was not available.We were told initial findings identified similar causal reasons to those previously identified in other cases up to a year earlier. These findings had not been shared.
- The children's directorate risk register highlighted 'failure to ensure the ongoing monitoring of SUI [serious

untoward incident] recommendations are appropriately incorporated and executed in action plans, could result in failure to learn lessons and to prevent avoidable harm in the future.

- To mitigate this risk the service stipulated that audits would be undertaken to review recommendations being implemented. We requested a copy of the audit that was scheduled to be undertaken in January 2016. This audit had not been completed at the time of our inspection.

Other incidents - Paediatrics

- From February 2015 – January 2016 trust data showed there were 153 incidentsreported on the children's ward and Koala unit. Most of these incidents (75%) were risk assessed as no harm incidents.
- On the paediatric unit the matron had recently introduced weekly meetings between governance leads and ward managers so incidents could be reviewed and appropriate action taken. However, we found 36 incidents that had not been reviewed at the time of our inspection.
- During our inspection at NMGH on paediatrics we observed four incidents and found no evidence these incidents had been reported.
- During our inspection there was delayed incident reporting (24 hours) in one safeguarding incident. At the time of our inspection we expressed concern about this and a senior nurse submitted the incident, rather than the staff member concerned due to her time constraints.
- In the paediatric unit we found a culture where staff were used to not reporting incidents. This meant that the trust board could not use incident reporting as an assurance mechanism for patient safety.
- On the paediatric unit nursing staff explained if they were directly involved in an incident, provision of feedback was not consistent. The nursing staff we spoke with explained they got feedback on incidents involving medications and sometimes for other things, e.g. staffing. All nursing staff told us that the ward meetings mainly discussed medication errors. We requested a copy of the meeting minutes but did not receive them.
- The trust's governance report indicated that the risk level within paediatrics was increasing. Senior staff told us that this was probably based on there being an increase in the numbers of incidents being reported within the last quarter. However, senior staff were aware that incident reporting had recently decreased and that staff were not reporting all incidents. Staff not reporting incidents was not recorded as a risk on the divisional risk register We were not assured senior managers within the trust had a clear understanding of the increased risk.
- The paediatric unit had a quarterly morbidity and mortality meeting where relevant cases were discussed. However, there was a lengthy delay before serious cases were presented at these meetings and discussed. This meant there was a risk of incidents recurring before immediate learning from serious untoward incidents had been shared.
- The paediatric nursing staff we spoke with were unaware of morbidity and mortality meetings or any recent outcomes/learning. However, on both units medical staff reported that they were informed about morbidity and these cases.
- During our review of incidents we noted six incidents where children had absconded from the paediatric ward. Nursing staff told us these incidents related to CAMHS (child and adolescent mental health service) children absconding from the ward (5) or parents taking children home against medical advice. Staff members told us they contacted security with a description of the patient and followed the trust's child abduction policy. At the time of our inspection this policy was out of date.
- Staff told us that they were aware of the duty of candour as a duty to be open and honest to people. However, in the incidents we reviewed, it was clear that duty of candour principles were not correctly followed in relation to serious incidents. In both cases we reviewed the trigger for the incidents being investigated were patient complaints. The RCA's showed no evidence that duty of candour principles had been followed at the time the incidents occurred. However, the trust has assured us the duty of candour was followed after the incidents had been investigated.
- We found that when concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. In the two paediatric steis incidents, there was a five-month

and a month's delay in the incidents being identified. The incident investigations took seven months in the first case and five months in the second case. There was little evidence of learning from events or action taken to improve safety. This represented a patient safety risk.

Other incidents – neonatal

- On the neonatal unit from February 2015 – January 2016 399 incidents were reported. Most of these incidents (78%) were risk assessed as no harm incidents.
- At the time of our inspection the neonatal unit had 65 open incidents that had not been investigated over an 18 month period.
- We asked matrons about this and were informed that on neonatal a backlog had arisen due to staff capacity issues resulting in fortnightly governance meetings not occurring. The neonatal matron had looked at the incidents to identify any that needed immediate action, but the incidents had not been fully investigated.
- In neonatal we found a culture where staff were encouraged to report incidents and a link nurse reviewed incidents one day per week . However, some medical and nursing staff told us they were not reporting all incidents. Senior managers within the division told us they were aware of this and that they reminded staff to report incidents. However, no further action was taken against staff who did not report incidents.
- The neonatal unit had a monthly perinatal meeting where cases were discussed and learning resulting from them was shared/confirmed had been actioned. Minutes from the meeting were shared within the division and were a standing item on the divisional quality and performance meeting.

Cleanliness, infection control and hygiene

- Trust audits to MRSA and C.Diff were reactive. From June 2015 to October 2015 the children's wards, Koala unit and the neonatal unit were not audited for C.diff or MRSA.
- On the paediatric ward the ward manager informed us that infection control audits were undertaken twice monthly. We found no evidence of this.
- The paediatric ward at NMGH were audited in August 2015. The ward were 67% compliant with hand hygiene. We saw no evidence there was a re-audit in the information provided to us and saw no action plan to address this.
- The neonatal unit were audited in August 2015. They were 100% compliant with policies for infection control but scored 91% for use of PPE and 67% for their hand hygiene. The unit was re-audited in February 2016 and were 94% compliant with infection control policies. However, actions from this audit were not allocated by the time of our unannounced inspection. We escalated this issue to the neonatal matron, who had not been copied in on either of the audits and was unaware of the findings.
- In July 2015, the trust undertook an infection control audit (excluding MRSA and C.Diff) on the Koala Unit and the children's ward. This showed the unit was 76% compliant with the trust's infection control procedures. The trust target for compliance was 85% or more. At the time of our inspection not all the recommended actions were assigned to people for completion and there was no re-audit date listed.
- The infection control audit identified 42 actions including a concern with isolation procedures. During our inspection, we observed that in both isolation cubicles visitors did not wear PPE. On three occasions during our inspection we saw visitors not wearing PPE walking around the ward touching communal areas. Doors to both cubicles were left open. This is not in accordance with best practice and represents infection control risks to other children and visitors on the ward. We escalated these issues to the trust.
- On our unannounced inspection the issue with children' visitors had not been resolved. We spoke with a senior nursing staff member. She was unclear why the infection control risk had been escalated in the first instance, as she did not see the situations as risks. We discussed this in detail. We also alerted more senior nursing staff to the issue as practice had not changed.
- On 6 January 2016 the trust re-audited the children's ward and Koala unit. The unit had partial compliance with the infection control audit requirements. This audit identified 54 actions. At the time of our inspection the agreed actions in the action plan had not been assigned

to anyone. We confirmed this information with senior nursing staff during our unannounced inspection and escalated this issue to the Matron as the action plan actions had still not been addressed. We subsequently received a completed action plan which states the allocated actions were completed prior to our unannounced inspection.

- The trust cleaning policy required all staff to keep a log of areas and equipment that they cleaned. On the paediatric and neonatal ward, we found no cleaning logs completed. Nursing staff told us that the expectation was that they cleaned the equipment then returned it to the equipment area. They were unaware of any cleaning logs.
- During our inspection we requested sight of daily cleaning rotas. Cleaning staff explained they did not need to complete documentation to confirm cleaning had been done. The trust's cleaning policy states that cleaning schedules for all cleaning should be available to be inspected. We requested to see cleaning schedules from both the cleaning staff and the nursing staff. Cleaning schedules were not available which was a breach of the trust's policy. However, at the time of our inspection clinical areas appeared to be visibly clean.
- In the paediatric unit's play area there were books/toys for children. The books were not covered. Staff explained they cleaned them by wiping them down with a wipe or detergent spray. When questioned as to what happens if a toy or book was used by an infectious child, nursing staff indicated that the toys and books would be discarded by cleaners. However, other staff told us the equipment was cleaned then returned with the other toys and books. This represents an infection control risk which was escalated at the time of our inspection.
- Staff explained toys were cleaned on a weekly basis. The trust's cleaning policy states that toys should be cleaned on a daily basis. Rotas were not regularly completed and did not evidence weekly cleaning took place.The ward were made aware of this in an infection control audit in 13 November 2015 and were reminded about this on 11 February 2016. We escalated this risk to the Matron.
- Babies requiring treatment for jaundice were admitted to the paediatric unit for phototherapy rather than the postnatal ward. This represented an infection risk to babies and is not in accordance with best practice.
- On the Koala unit there was a cubicle for isolation purposes and use by young children. This did not have a toilet and sink. Staff told us that they managed this risk by using a commode. This did not resolve the infection control risk presented by the absence of a sink. We escalated this to the trust.
- Hand gel was readily available on entry to each clinical area and visitors were reminded to use this by staff. However, no hand washing facilities were available at the entrance to the children's ward or the neonatal unit. This represents an infection control risk.
- There were no hand washing facilities in the treatment room in paediatrics. This represented a decontamination and infection control risk. This issue was escalated to the trust during our inspection.
- On the neonatal unit staff and parents shared the same fridge.
- We reviewed the cleaning audits provided by the trust's cleaning contractor. These showed good compliance scores for all units (over 91%) in the monthly audits the contractor undertook.
- On the neonatal unit, fresh and frozen milk was stored in tamper proof containers.

Environment and equipment

- On the paediatric and neonatal units door entry systems were key coded and had video entry systems. Swipe cards were used to exit the ward areas. This represents good practice. However, a risk had been identified in that staff let members of the public onto the children's ward that needed to use the toilet. This represented a potential safeguarding risk to the children on the unit. Staff were aware of this risk and told us there was a plan in place to close the children's ward entrance and that all children would come through the Koala unit entrance, which was located further within the hospital. A date had not been set for the work to be started.
- The door entry risk was identified by the trust in a 'WOW week' walk about but the risk is not on the divisional risk register. We requested a risk assessment for this and have not received one.

- During our inspection, we found equipment that did not have up to date maintenance review stickers in place on it. PAT testing was up to date on approximately 50% of the equipment.
- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. We reviewed an equipment maintenance assurance log. On the neonatal unit this log showed that of 48 low risk items, 40 were out of date for their routine maintenance. The time period this equipment was out of date for was from six months to over six years. Out of 199 medium risk items, 141 were out of date for their routine maintenance. 97 of these items were out of date for over one year. These included respiration/apnoea monitors, vital signs monitor and infant warmers. Out of 83 high-risk items, 14 were out of date for their routine maintenance. This included high-risk items including ventilators which hadn't been tested for between six months - four years and infant resuscitaires that hadn't been tested for four years.
- This meant the trust board had no assurance that those items, which included high risk items such as resuscitaires and ventilators, were adequately maintained and working correctly. However, from December 2014 – December 2015 there were no incidents reported that occurred as a result of equipment failure.
- On the paediatric unit the maintenance log showed that of 139 low risk items, 96 were out of date for their routine maintenance. The time period this equipment was out of date for ranged from six years to over a month. 26/40 of the items were over a year out of date. Out of 147 medium risk items, 111 were out of date for their routine maintenance. The time period this equipment was out of date for ranged from six years to one month. 78 of these items, which included suction units, flowmeters and vital signs monitors were out of date by over one year. Out of 58 high-risk items, 118 were out of date for their routine maintenance. The time period these items were out of date for ranged from 17 months to one month. This meant the trust had no assurance that those items, which included high-risk items such as resuscitaires and ventilators, were adequately maintained and working correctly. However, from December 2014 – December 2015 there were no incidents reported that occurred as a result of equipment failure.
- On the paediatric unit, most rooms were locked and accessible by key codes e.g. storage, kitchens, utility, and drugs. However, the treatment room was unlocked. This allowed access to a range of equipment including lumbar puncture needles. This represented a potential risk to childrenand had previously been identified as a concern during an infection control audit in July 2015. This issue was not on the risk register. We told the trust about this and the door was locked. On our unannounced visit the treatment room was unlocked. However, all equipment was either secure in cupboards or had been moved so it was behind keycoded doors.
- On the Koala unit and the paediatric unit the sharps bin lids were not closed using the temporary closure mechanisms. This issue had previously been identified as an infection control concern during the infection control audit in July 2015. We told the service about the this. On our unannounced visit the temporary closure mechanisms were still not secured. We escalated this to the Matron.
- The paediatric ward and Koala unit each had resuscitation trolleys. These trolleys were not tagged. On our unannounced visit the trolleys were tagged.
- On the paediatric unit, the equipment in the store was not plugged in to charge it. The equipment was difficult to see and find. The room was cluttered and disorganised. This could lead to delays in accessing equipment in an emergency, which represents a patient safety risk.
- On the paediatric unit, the bottom of a food fridge was broken resulting in the element being exposed. We escalated this risk and an electrician attended the ward and fixed it.
- On the paediatric ward, the food fridge contained uncovered juice jugs. This represented a contamination risk. We escalated the risk during our inspection. On our unannounced visit the food fridge did not have any juice jugs in it.
- On the neonatal unit, the store cupboard was full of equipment and cluttered. It was not easy to access

equipment in an emergency. There were no plug sockets in the room to charge electrical equipment. This could lead to delays in an emergency, which represents a risk.

- On the neonatal unit, the grab bag did not have a checklist and it was not sealed at the time of our inspection. However, it did have all the correct equipment in it that was in date. We escalated this issue to the trust.

Medicines

- Drugs requiring storage below certain temperatures were stored in fridges. Whilst checks were in place to monitor fridge temperatures, on three dates the fridge was showing a lower temperature (0.7 degrees). On two dates, the temperatures were not recorded. We escalated this issue, as there was no recorded evidence that action had ensued following the temperature findings. On our unannounced visit the fridge temperatures were recorded and the fridge was running within normal parameters.
- In the recovery area of the paediatric theatre there was a medications' fridge. This was not checked on a daily basis and contained temperature sensitive drugs. We escalated this issue with the trust and it was immediately addressed.
- On the neonatal unit, staff told us that it was not easy to access IV fluids in a rush. The cupboard where IV fluids were stored was locked, which is good practice. However, the fluid bags were stored within cardboard boxes which were cramped restricting access. Concern was expressed that in an emergency this could lead to a delay. Staff told us this issue had been discussed 'as a team' but had not reported as an incident. No further action/change in practice had occurred as a result of the discussion.This situation represents a risk that had not been addressed. We escalated this to the neonatal matron.
- Children were weighed and this was documented within their medical records.
- The service had electronic prescribing in paediatrics. This system highlighted prescribers to patient's allergies and drugs they may be sensitive too. Patient's weights were also added to the electronic prescribing system. The system then calculated the required dosage of specific medications that a patient needed. On the neonatal unit prescribing charts were paper-based and contained within medical records.
- Staff told us children wore red wristbands when they have an allergy and that the allergy would be documented in the medical records.
- An antimicrobial audit undertaken in July 2015 indicates that both the paediatric and neonatal unit were 100% compliant with quality antimicrobial prescribing.
- The service had a designated pharmacist.
- We checked the drugs audits on the paediatric and neonatal units and they were all fully completed confirming that all drugs were in date.
- The neonatal unit attended a bi-monthly Safe Administration of Medicines group (SAMs) where all staff were invited to discuss incidents regarding medication.
- On the neonatal unit the resuscitation trolleys were fully equipped and regular checks were evidenced to have occurred.

Records

- During our inspection we reviewed 11 sets of records for the paediatric unit. In all 11 records, not all entries were fully legible; not all entries had dates and/or times recorded and EWS (early warning scores) were either partially completed or not completed. This breached the trust's EWS policy and represented a patient safety risk.
- Paediatric nursing records were difficult to navigate. This meant that finding relevant information took extra time.
- In the patient records we reviewed, patient information data was not on all pages and growth charts were not included. When observation charts were partially completed, the actual observations were unclear and messy. However, pain scores were completed and consent forms, where required, were appropriately completed.
- We reviewed 11 sets of neonatal notes. In seven sets of notes, the growth charts were not completed. In all sets of notes the entries were not consistently completed (signature/ date and designation of the person

completing them). Two sets of notes contained records that were not on the trust's paperwork. In one set of records there was no transfer paperwork, which we would have expected to see as the patient had transferred in from another hospital.

- Of all the notes we reviewed, only one set had a fully completed patient risk assessment. The rest were not completed or only partially completed without scores being totalled.
- Records were stored securely in locked cabinets.

Safeguarding

- The trust had set a target that 60% of staff working with children and young people had to have level three safeguarding training. In the children and young people's service at North Manchester General Hospital the trust advised us that 72% of staff in paediatrics had completed this training and 30% of neonatal staff had completed this training. The neonatal figure is below the trust's own target.
- The trust's own target is not in accordance with the national guidance from the intercollegiate document 'Safeguarding children and young people: roles and competences for health care staff' which states that 100% of staff should be level three trained.
- We escalated these issues with the trust as they were not recorded as a risk on the risk register.
- Staff we spoke with were aware of safeguarding procedures and who to report incidents too. During our inspection we observed a safeguarding incident that took place. Whilst steps were taken to inform relevant authorities, an incident report was not completed for 24 hours and the statement was not completed for 24 hours. We escalated this issue with the trust.
- On the children's unit there was not a designated teenagers' bay. This meant that older children/ teenagers and younger children may share the same bays. At the time of our inspection younger and older children were nursed together. We asked senior nurses about this. They informed us that they risk assessed the areas where children were admitted on a case-by-case basis dependent on bed availability. Senior staff advised us they did not document their risk assessments.
- We were informed that CAMHS children were not admitted to cubicles because of safety risks.
- The trust had a current female genital mutilation policy.
- At induction all staff are given a PREVENT leaflet to make them aware of their responsibilities.

Mandatory training

- At the time of our inspection, none of the paediatric nurses had APLS training. Service leaders were unclear how many staff were up to date with their mandatory training. We requested this information from the trust. They informed us that 13/46 (28.3%) nursing staff had current PILS certification on paediatrics and that 11/32 (34.4%) nursing staff had current NLS certification on neonates.
- The trust target for staff being up to date with their essential job related training is 90%. We were provided with conflicting data during our inspection regarding training and the number of staff that had completed it. We requested specific mandatory training figures for medical and nursing staff at the time of our inspection.
- The subsequent data provided by the trust showed that in paediatrics at NMGH 50% of medical staff were up to date with their essential job related training. 30% of nursing staff were up to date with their essential job related training. 55% of staff who provided additional clinical services were up to date with their training. 50% of administration staff were up to date with their training. We escalated this to the trust.
- In neonatal at NMGH 46% of nursing staff were up to date with their mandatory training. 63% of staff who provided additional clinical services were up to date with their training. 100% of administration staff were up to date with their mandatory training. The majority of these figures fell below the trust's target of 90%. We escalated this to the trust.
- Medical staffing levels met quality standard IP-203 of the Paediatric Intensive Care Society Quality Standards for the Care of Critically Ill Children.

Assessing and responding to patient risk

- During our inspection we reviewed 11 sets of records for the paediatric unit. In all 11 records, not all entries were fully legible; not all entries had dates and/or times

recorded and EWS (early warning scores) were either partially completed or not completed. This breached the trust's EWS policy and represented a patient safety risk.

- In the Manchews EWS (an early warning score system), observations are plotted onto a chart. The chart is colour coded to indicate when staff members need to take different management actions, e.g. increased observations. The EWS data was on photocopied sheets, which did not make the colour system clear. In all four active patient records there were no Manchews scoring charts as a reference guide. It is good practice for this reference guide to be available to staff so they are clear on the actions expected from them depending on the patient's current observations.
- At our inspection we found evidence that EWS had been partially completed and not acted upon.Senior staff told us they were aware that there were still issues and further serious untoward incidents had occurred where EWS completion and escalation had been identified as causal factors.
- The paediatric unit used MANCHEWS as their early warning score system (EWS). In all the medical notes we reviewed we found that EWS records had not been fully completed. Following an earlier serious untoward incident, failure to complete and escalate early warning scores had been deemed a causal factor in this incident. The recommendation from this review was that audits were undertaken to assess compliance with the EWS policy.
- The trust audited EWS completion in May 2015. This showed that only 34% of the records they reviewed had EWS fully completed on admission.
- We requested more recent audit evidence and an action plan. The trust advised us that no further audit had taken place.
- Across the trust two serious incidents over a year outline failure to respond to escalating EWS as a causal factor. We were not assured that the trust had given sufficient priority to addressing this risk.
- Nursing staff on the paediatric unit did not have APLS training. At the time of our inspection 13/46 nursing staff members had current PILS certification. We escalated these issues to the trust as immediate patient safety risks.
- On the Koala unit, children were admitted by a ward clerk then sent to the waiting area. Children were then taken to the Koala unit when a trolley became available for assessment. The waiting area was not easily visible to Koala unit staff or ward staff. Whilst children were initially triaged when they came to the waiting area, further checks were not undertaken until they were on the unit despite the length of time they were waiting or their clinical condition. This represented a risk that children could deteriorate before being assessed.
- Paediatrics had child and adolescent mental health services (CAMHS) liasion service provided by Manchester Mental Health Service. They provided in-reach services to the Emergency Department and Paediatric Wards to assess children. Children requiring CAMHS were admitted directly to the ward and were seen by the CAMHS team. Children remained inchildren until a specialist bed became available. Paediatric referrals for mental health reasons were admitted to the ward for either paediatric physician management of acute medical conditions or as a place of safety to await CAMHS assessment. However, the ward had no Registered Mental Health Nurses.
- When a CAMHS patient required 1:1 nursing the trust used an agency staff member to facilitate this provision.
- Following anaesthesia designated staff manage children in the recovery area within theatre.
- On the neonatal unit EWS were not used. The trust were developing a deteriorating neonate policy at the time of our inspection but no implementation date had been set.

Nursing staffing

Paediatrics

- We requested evidence from the trust to assess their compliance with Royal College of Nursing (RCN) standards (August 2013) in accordance with best practice. This was to assess safe staffing numbers and skill mix in paediatrics.

- To assess whether a paediatric unit has safe staffing levels, it is essential to know the number of children and their acuity along with the skills mix of staff.
- The trust was unable to identify the children in HDU during the time period (10 January 2016 - 9 February 2016) we requested.
- The trust was unable to identify the number of children in HDU for the month (10 January 2016 – 9 February 2016) prior to the inspection.
- The trust was unable to use its data to tell us how many children were on the paediatric ward for each shift.
- The trust did not routinely use an acuity tool, as recommended by RCN guidance, at the time of our inspection. However, in December 2015 the trust trialled an acuity tool for one week (19 shifts). At the time of our inspection no plans were in place to introduce an acuity tool.
- RCN guidance for safer staffing recommends a staff ratio of 1:3 for children under two years of age and 1:4 for children above 2 years of age. For children requiring HDU care the ratio 1:2 is recommended.
- We found that 19 out of 20 shifts (95%) were not staffed in accordance with RCN guidance in terms of the recommended staff: patient ratio. On average each shift was understaffed by two registered nurses.
- No staffing incidents were reported whilst the acuity tool was being used. This meant that shift co-ordinators either failed to recognise that the ward was short staffed or failed to report an incident which was their responsibility.
- We reviewed the planned vs actual staffing figures on the ward. In 32 out of 92 shifts (34.78%) nurse staffing was at least one registered nurse short. Planned staffing did not appear to take into consideration that just over 50% of the children that attended the ward were under two years old.
- Royal College of Nursing (RCN) standards (August 2013) recommend that there is a senior children's nurse available for advice at all times throughout the 24-hour period. The trust did not have this provision in place on 46 of 93 shifts (49.5%) over a month.
- Royal College of Nursing (RCN) standards (August 2013) recommends that a nursing staff member has APLS/EPLS training at all time throughout the 24 hr period. The trust did not have any APLS/EPLS trained nursing staff members in paediatrics. They informed us that 13/46 (28.3%) nurses had current PILS certification on paediatrics.
- To gain assurance that the paediatric ward had nursing staff with some level of current life support training, we reviewed the rotas for the month (10 January 2016 – 9 February 2016) prior to our inspection. This showed that 78.8% of nursing staff on shift had basic paediatric life support training.
- On the paediatric unit from December 2014 – December 2015 nine incidents were reported regarding staffing. Six of these incidents were risk assessed as no patient harm cases, one was assessed as low harm and two were assessed as moderate harm. In one incident it was recorded that children had delayed reviews by 3-4 hours, medications had not been prescribed or were given un-prescribed by nurses because of patient acuity. In other incidents staff reported not being able to take breaks and staying past the end of their shifts.
- Nursing staff told us that regularly they did not take all their breaks.
- Over the six months prior to our inspection the average sickness rate for paediatric nursing staff was 6.8%. This was above the trust's target of 4.0%.
- Failure to achieve safe staffing levels across the division had been recorded on the risk register since 28 November 2014. Controls were outlined that included reassessment of clinical workload in relation to nurse/patient ratio and the booking of bank staff to cover shortfalls.
- Insofar as reassessment is concerned, the escalation policy the trust used did not follow the RCN guidance for the ratio of staff to children. We escalated this and this was updated prior to our unannounced inspection.
- Nursing staff told us that prior to our inspection the ward was never closed to all admissions, only to A&E admissions (approximately 402 children per month). This was in accordance with the trust's escalation policy. NMGH admits approximately 295 children per month as

GP admissions. This meant that although some attempt at risk reduction had taken place, senior staff did not adequately mitigate the risk presented by the staffing deficit as the ward didn't close.

- The trust could not tell us the number of times beds had been reduced to address staff shortages as their bed management system did not record this information.
- Nursing leads told us booking of nursing staff had proved more problematic recently as the trust had stopped using a local agency due to costs. Following escalation of our concerns regarding staffing, the trust started reusing the local agency.
- We saw evidence of clinic cancellation because of the staffing situation, evidencing impact on patient care.
- Medical staff expressed concern regarding nurse staffing, particular at night. They explained that they could not get admissions into the ward. Medical staff reported having to ring around different units, which was reported to be time consuming, to find beds and reported that children had recently been sent to Nottingham and Derby.
- No acuity tool was used to plan staffing levels or skill mix on the neonatal, paediatric or the Koala units. An acuity tool had been trialled but this had not been implemented at the time of our inspection.
- There is reliance on bank and locum staff within the paediatric service for medical and nursing staff. Agency staff were reported to have received appropriate paediatric training and staff told us that agency staff were given computer access during their shifts. However, three incident reports we reviewed indicated that this was not consistently happening.
- High dependency children are nursed on the paediatric ward were staff had not received additional training for this this dependency of patient. This is against Paediatric Intensive Care Standards.
- There were ward clerks from Monday to Friday from 9:00 to 17:00 Monday-Friday. Outside these times nursing staff did their own administration and managed the door entry systems.
- We observed an MDT (multi-disciplinary team) handover. The handover was not protected and had several interruptions. Nursing staff challenged medics appropriately and communication between the teams was good. Needs of families were considered as well as children' needs.

Neonatal

- The neonatal unit used guidance from the British Association of Perinatal Medicine (BAPM) with regard to staffing levels. They planned, using BAPM standards, for 90% occupancy.
- We reviewed neonatal staffing in line with BAPM (British Association of Perinatal Medicine) guidance over the course of a month. In 49/93 shifts (52.8%) nurse staffing did not comply with BAPM guidance for the nurse:patient ratio. On average the unit was understaffed by at least one registered nurse. When we reviewed the planned vs actual staffing information, this showed in 60/93 (64.5%) of shifts the unit was understaffed by at least one nurse.
- On the neonatal unit from December 2014 – December 2015 16 incidents were reported regarding staffing. 12 of these incidents were risk assessed as no harm incidents, two incidents were risk assessed as low harm, one incident was moderate harm and the other was a 'near miss' incident. In three incidents it was recorded that babies did not receive their feeds on time, staff were unable to take their breaks and that babies had delayed medications.
- There were 16 incidents reported from December 2014 to December 2015 regarding nurse staffing. On three of these occasions there was evidence, recorded in incidents, of delayed medication and feeds, thus evidencing an impact on patient care.
- The planned and actual staffing levels were displayed on notice boards at the entrance to the children's ward, Koala unit and the neonatal unit. They were updated on a daily basis. During our inspection one staff member altered the planned staffing information to match the actual staffing on the ward. When we queried this, the staff member confirmed that the figures should not have been amended as the planned staffing levels do not change day to day.

- 34.4% nurses had current NLS certification on neonates. BAPM guidance states that all practitioners working with neonates should have NLS certification. We raised this issue with the trust at the time of the inspection.
- Over the six months prior to our inspection the average sickness rate for neonatal nursing staff was 6.5%. This was above the trust's target of 4.0%.
- Over the six months prior to our inspection the average sickness rate for non-registered nursing staff was 15.8%. This was above the trust's target of 4%.

Medical staffing

- The percentage of consultants working in paediatrics within the trust was 32% which was less than the England average of 35%. The percentage of registrars was 50% which was less than the England average of 51%. 12% of the medical staff were junior doctors, which was higher than the England average of 7%.
- The trust had seven paediatric consultants in post and three locum consultants. Their rotas were reported to be consistently covered and were compliant with the European working time directive (EWTD).
- The consultants took part in a 'hot week' rota. They were present on the children's ward from 9am to 5pm. On call paediatric, consultant cover was also available from 5pm to 9am Monday to Friday and at weekends. The paediatric ward had registrar and junior doctor cover 24 hours.
- Facing the Future Standards recommend there should be consultant presence on the ward at self-defined peak times. Hospital staff told us that their peak times were between 4pm and 9pm. The hospital had consultants' scheduled to be on site up unitl 5pm. We raised this issue with the trust. They confirmed that consultant presence during peak times was not in place. The trust advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.
- Facing the Future Standards recommend that every child who presents with an acute medical problem is seen by a consultant, or equivalent, within 24 hours. In one paediatric serious incident investigation we reviewed this had not occurred and was deemed a causal factor in the delay of diagnosis. The trust did not monitor this standard at the time of our inspection.
- On the neonatal unit, paediatric consultants cover the rota. The consultants took part in a 'hot week' rota when they would be present on the neonatal unit 9am to 5pm. On call consultant cover was also available 5pm to 9am from Monday to Friday and at weekends. The neonatal unit had registrar and junior doctor cover 24 hours a day.
- At the time of our inspection, clinical leads informed us that consultants were stepping down into registrar vacancies to ensure the wards had appropriate medical staffing. Whilst this specific issue is not on the risk register, failure to achieve safe staffing across the division is. Clinical leads told us they were working on new rota's for medical staffing. However, a definitive date for implementation of the new rota's was unknown at the time of our inspection.
- We observed a medical handover on the paediatric unit. This was appropriate with identification of learning points for junior team members.
- There were two consultant led handovers in place every day.

Major incident awareness and training

- The trust has a major incident policy on the intranet that was available to all staff. Nursing staff told us that they did not practice for major incidents.
- Staff on both the paediatric and neonatal unit told us they were aware of their roles and responsibilities if there was a major incident.

Are services for children and young people effective?

Requires improvement

Overall, in terms of being effective, we judged that the neonatal and paediatric services at North Manchester General Hospital required improvement.

- We found that care and treatment did not always reflect current evidence-based guidance, standards and best practice because 8/64 policies and procedures were not up to date. These included policies for pain, diabetes and child abduction.
- On the paediatric unit we found Partners in Paediatrics (PiP) guidance had recently been put in place. However, this had not been adapted to include trust contact numbers to make the guidance work as effectively locally particularly for junior medical staff or locum staff members. .
- On the neonatal unit resuscitation was undertaken with 100% oxygen which is not in accordance with best practice and presents a risk of retinopathy of prematurity (can cause sight defects, or even blindness).
- Children received care from staff who did not have the skills that are needed to deliver effective care. There were very low numbers of nursing staff who had current PILS certification, no nursing staff had APLS training and 34.4% staff had current NLS certification.
- Trust targets for essential role specific training were not achieved. This meant staff did not have their skills refreshed.
- Whilst staff felt supported in additional training and development, basic training needs including safeguarding were not appropriately addressed.
- There were gaps in management, supervision and support arrangements for staff and appraisal figures were very low and below the trust's target.

However;

- Consent was appropriately obtained for surgical procedures
- Patient's pain was appropriately monitored.

Evidence-based care and treatment

- Policies and procedures were provided on the trust's intranet. The trust has a flagging system to indicate when policies were coming up for revision and when they were out of date. However, at the time of our inspection eight out of 64 policies were out of date. These included policies for pain, diabetes and child abduction.
- At the time of our inspection the paediatric service had recently introduced Partners in Paediatrics (PiP) guidance. However, this had not been localised to the trust. This meant that whilst there was guidance on what to do, how to do this within the trust and who to contact within the trust was not available. As a result of this the guidance did not work as effectively as it could for junior medical staff and locum staff because they had to look elsewhere for this information. We asked senior staff about this and were told that the service was in the process of developing further guidance. A definitive deadline for when they would be available was not provided.
- A review of policies and procedures was scheduled, as part of the paediatric improvement plan, to be undertaken at the end of February 2016. On our unannounced inspection in March, the clinical lead told us this review had not been undertaken and seven out of eight policies remained out of date.
- NICE guidance requires transition pathways to be in place. With the exception of diabetes, and neuro-disability, transition arrangements were not in place within paediatrics. However, the trust did recognise that it required significant improvement in this area and had recorded on the paediatric improvement plan that on 29 February 2016 they would begin to address this need going forwards.
- The paediatric service did not offer other transition pathways at the time of our inspection. However, the trust did recognise that it required significant improvement in this area and had an action plan in place to help them begin to address this need going forwards.
- The neonatal unit had been audited to assess its current position in relation to an application for Baby Friendly accreditation. The audit we received highlights several required actions. We requested an action plan for this but have not been provided with one. However, we have seen meeting minutes following the audit which highlighted some steps that had been put in place.
- Whilst the median glycaemic level is similar to that of England (Trust 74, England 72mmol/mol), NICE define excellent diabetes control as HbA1c levels less than 58 mmol/mol as this indicates good glycaemic levels. The higher the HbA1c levels the greater the risk of complications. 16% of the Trust's children were reported as having a HbA1c under 58 mmol/mol which is a lower proportion of children with well managed diabetes than the England average of 19%.
- We reviewed the incidents reported in the paediatric unit and found 34 incidents were reported between January 2015 to January 2016 where staff members did

not follow appropriate policies and guidance. 30 of these incidents were risk assessed as no harm incidents, three incidents were categorised as low harm and one incident was a 'near miss'.

- On the neonatal unit there was no facility for mixed air flow for babies. This meant that neonates could only be given 100% oxygen or 21% oxygen during resuscitation. The risk to babies of receiving 100% oxygen is that they can develop a condition of the eyes known as retinopathy of prematurity which can cause sight defects, or even blindness and thus best practice is the delivery of blended oxygen during resuscitation.
- The trust advised us that the period of time that babies receive 100% oxygen is limited. They did not deem their current practice to pose a risk to babies. As such, the risk that was previously on their risk register in 2013 was closed. However, the document for this specific risk identified the action taken to reduce or control this risk was replacement of old equipment with appropriate equipment fitted with blenders and that all new equipment had to have blenders included. At the time of our inspection we did not find evidence that the equipment had been replaced as outlined above.
- Best practice is for babies to receive blended oxygen. We did not find evidence that the trust had implemented its own control measures for this risk, prior to closing the risk.
- The Trust performance in mortality reduction against other trusts nationally as shown in the Dr Foster Hospital Guide 2012 and through mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Indicator (SHMI) was shown to be deteriorating. The neonatal team recognised this and that efforts needed to be made to reverse this trend and ensure the drive to reduce avoidable deaths and avoidable harm. The neonatal team had monthly perinatal meetings where cases were discussed, actions were identified and learning was shared with paediatricians, obstetricians, neonatologists and trainees. Minutes from these meetings were shared with nursing staff, medical staff and multi-disciplinary team members by email and circulation of hard copies of the minutes.

Pain relief

- The trust's pain policy was out of date at the time of our inspection. However, pain scores were completed within the medical records we reviewed and children told us their pain was monitored.
- The friends and family test showed that parents felt that they did not receive clear and consistent explanations when liaising with nursing and medical staff. However, during our inspection the parents we spoke with explained that they felt that staff gave them clear explanations regarding medication and analgesia.
- Analgesia and topical anaesthetics were available to children who required them on the ward.

Nutrition and hydration

- On the paediatric unit children were given a choice of meals from the serving trolley. Nursing staff were able to order meals from the kitchen, before 6pm, to cater for different dietary requirements.
- Nursing staff created meal boxes for Jewish families.
- Snacks and drinks were available on request.
- The service had dietetic input from a dietician.
- Breast pumps were loaned to women to encourage feeding of breast milk.

Patient outcomes

- The trust's multiple (two or more) readmission rates are higher than the England average for asthma, diabetes and epilepsy for 1-17 year olds. The England average for asthma is 16.8%, for diabetes is 13.6% and for epilepsy is 27.8%. The trust's average for asthma is 19.1%, for diabetes is 17.3% and for epilepsy is 33.8%.
- In the National Neonatal Audit Programmes (NNAP) the neonatal unit at NMGH scored below the national average in 3/5 questions. NNAP standards include that 98%-100% of babies (that are born at 28+6 weeks gestation or older) should have their temperature taken within an hour of birth. At NMGH 86% of babies had this done within the timeframe.
- A NNAP standard is that 100% of eligible babies should receive ROP screening within the timeframe provided. At NMGH 96% of babies received this screening in the correct timeframe.
- NNAP benchmarks the percentage of babies that receive any of their mother's milk at the time of discharge at 58%. At NMGH 70% of babies received their mother's milk at the time of discharge which is above the national average.

- NNAP outline that 100% of parents should be consulted by a senior member of the neonatal team within 24 hours of admission and that this consultation should be documented. At NMGH they achieved this in 96% of admissions.

Competent staff

- The service had a funded escalation bed which is located in a separate cubicle. This bed was managed as a HDU bed and was used for treatment of children who are described by the Paediatric Intensive Care Standards as receiving level one care. The trust told us that specific HDU training was not provided for paediatric staff. This is against Paediatric Intensive Care Standards which state that "Children needing high dependency care should be cared for by a children's nurse with paediatric resuscitation training and competences in providing high dependency care."
- Staff we spoke with confirmed that they were not up to date with their appraisals.. At NMGH 55% of paediatric staff were up to date with their appraisals.
- At NMGH 69% of neonatal staff were up to date with their appraisals.
- The trust has a target that 90% of staff should have completed their essential job related training. The trust has provided us with conflicting data regarding this. At NMGH neonatal unit 74% of staff have completed their training. In paediatrics 61% of staff have completed their training. All these figures are below the trust's target of 90%. We escalated this issue to the trust.
- Staff told us that the trust had supported them in funding educational development.
- Staff on the neonatal unit were given the opportunity to work in the trust's level three unit at Oldham to develop/ refresh their skills.
- In the neonatal unit there was an education team. This team worked to provide for education needs and also completed clinical practice. As neonatal staff were regularly called to support staffing on the paediatric unit, the neonatal education team liaised with the paediatric practice educator to arrange for staff members' training needs to be addressed.
- The paediatric team had one paediatric practice educator who worked across all four sites. They supported induction for new staff members and training needs that arose within the team.

Multidisciplinary working

- We observed an MDT (multi-disciplinary team) handover. The handover was not protected and had several interruptions. Nursing staff challenged medics appropriately and communication between the teams was good. Needs of families were considered as well as children' needs.
- The paediatric unit and neonatal unit had designated pharmacists.
- Physiotherapy provided a five-day service accepting referrals from acute consultants in paediatrics, orthopaedics and A&E. During the four months prior to our inspection the maximum wait for non-urgent referrals was 6 weeks. At the time of our inspection urgent referrals were offered appointments within 7 working days.
- There was a full-time speech and language therapist in post offering support to the paediatric and neonatal units five days per week.
- The paediatric unit had access to a dietician.
- The trust had play specialists available Monday-Friday from 9am – 5pm. These staff worked at North Manchester General Hospital.

Seven-day services

- Consultant on-call cover was provided out of hours.
- Seven day services were provided on the paediatric unit, on the Koala unit and on the neonatal unit. The paediatric and neonatal wards had access to diagnostic imaging for emergencies seven days a week.

Access to information

- Policies and procedures were kept on the trust's intranet and staff were familiar how to access them.
- When children were discharged from hospital a discharge letter was either sent by email or in the post to their GP. A discharge summary was also provided to parents.
- GPs could access telephone advice from a paediatrician within the Koala unit.
- On the neonatal unit measurements and any vaccinations given were recorded in a Personal Child Health Record (PHCR).

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Consent

- Staff were aware of appropriate procedures in obtaining consent and described how Gillick competence was assessed to establish if children had the maturity to make their own decisions and understand the implications of treatment.
- We observed consent forms in place where adults and parents could co-sign to consent to procedures.

Are services for children and young people caring?

Requires improvement

Overall in terms of being caring, we judged that the neonatal and paediatric services at North Manchester General Hospital requires improvement.

- Staff told us there were times when they had to focus on the task they were undertaking rather than treating people as individuals to ensure that essential jobs were done e.g. provision of medications.
- During our unannounced inspection staff told us that their ability to spend time with children and provide support had improved significantly.
- Friends and family test results were poor, but parents and children on the ward at the time of our inspection did not support the tests findings.

However;

- On the neonatal unit staff interactions were positive and babies were treated with kindness and compassion.
- In paediatrics during our unannounced inspection we saw staff engaging with children and their parents kindly.
- Parents and carers were, in the main, positive about the care and treatment provided. They felt supported and involved in the planning and decisions regarding their child's healthcare.
- Children were positive about their interactions with staff.
- People's social needs were understood.

Compassionate care

- In the 2014 CQC Children's survey the trust scored about the same as other trusts in 19 of the applicable questions. In five questions the trust scored worse that other trusts. These questions related to staff members availability; staff playing with children; staff caring for children listening to parents and carers; staff being friendly with children and parents being told different things by different people. The trust scored better than other trusts for the explanations provided to parents before procedures or operations.
- We discussed the findings of the CQC Children's survey with different staff members and also questioned parents and children regarding their experience.
- Parents we interviewed described staff as being approachable, chatty and friendly. However, they did comment that staff were always busy.
- We observed a number of interactions to be rushed and task based. We also observed children being left alone in cubicles that had not been made child friendly.
- All staff that we spoke with explained that they tried their best to provide compassionate care to children, but frequent low staffing meant it was challenging and that basic care needs were their primary focus. Staff acknowledged that there were times when they could not provide the explanations they wanted.
- We explored the play provision and found that when the friends and family survey was undertaken there were staffing shortages within the play therapy team. At the time of our inspection the team was fully staffed. Parents and children we spoke confirmed that children were offered a range of play activities.
- It was documented on the risk register that 'failure to deliver 3 improvements in Patient Experience measured through the Friends & Family test may result in continued poor patient experience and reputational damage for the Trust'.
- On the neonatal unit we observed patient interactions. Staff introduced themselves to parents prior to consultation. Doctors and nurses communicated with babies and their parents when interacting with them. Doctors and nurses provided explanations to parents so that parents could understand procedures. Babies names were used in interactions, parents were given opportunities to ask questions and staff were gentle and kind when handling babies and giving them feeds.
- Bereavement support was provided by the neonatal service.

Understanding and involvement of children and those close to them

- Parents were involved in care provision for their children.

Services for children and young people

- Children and parents told us they felt informed about their care.
- Information leaflets were provided to children on discharge.
- Parents were encouraged to stay with their child on the ward. There were folding beds at the bedside and an overnight rooms with en-suite facilities on the neonatal unit.

Emotional support

- Children admitted requiring CAMHS were supported by ward staff and agency workers if they required 1:1 support. However, there was no Registered Mental Health Nurse on the ward.
- Play specialists were available from Monday to Friday and supported children undergoing procedures on the ward.
- Play specialists did preparation work with children requiring surgery and accompanied all children and parents to theatre.
- In response to the children's survey, staff at all levels told us that to improve caring provision empathy training was now provided as part of induction and mandatory training.

Are services for children and young people responsive?

Requires improvement

Overall in terms of being responsive, we judged that the neonatal and paediatric services at North Manchester General Hospital requires improvement.

- We found that the needs of the local population were not fully understood when planning this service particularly when considering the number of under two's that would access the children's wards.
- Planned staffing did not appear to take into consideration that just over 50% of the children that attended the ward were under two years old.
- Some people are not able to access services for treatment when they need to. Over one month 21 children were transferred to other hospitals to receive their care. Over a year 98 clinics were cancelled.
- When people raised complaints there was a slow response. Complaints were not used as an opportunity to learn as action plan actions were not all allocated and appropriate follow up actions e.g. audits did not always happen.
- There were gaps in transition to other services. Transition pathways were only in place for diabetes and neuro-disabilities. This is not in accordance with NICE guidance or best practice.

Service planning and delivery to meet the needs of local people

- Planned staffing did not appear to take into consideration that just over 50% of the children that attended the ward were under two years old. During our inspection we observed that children were frequently left in the care of nursing staff by their parents and carers.
- The trust had recently had work undertaken on the children's ward to make the environment more child friendly. Artwork had been installed on the walls in the design of portholes. Games consoles and games were available as well as DVDs. We observed robot television units which incorporates a DVD player and a games system.
- Children were accommodated in mixed age/sex bays which meant that teenagers were accommodated next to infants.
- Cubicles lacked child friendly decoration.
- The trust did not operate wifi on the ward. The trust told us the issue had been risk assessed as a safeguarding risk. We requested the risk assessment but did not receive it..
- Parents were encouraged to stay with their child on the paediatric ward. There were camp beds on the paediatric unit. On neonatal there were en-suite transitional care bedrooms.
- There were designated parents rooms with suitable facilities on both units. The hospital provided access to hot and cold food.
- Meals were offered to breast feeding mothers on the paediatric and neonatal unit.
- GPs could seek telephone advice from paediatricians on the Koala unit.

Access and flow

- Admissions to the paediatric ward were through A&E, GP referrals and the Koala observation and assessment

unit. From August 2015 – 10 February 2016, 209 children under 16 (179 from NMGH) were transferred to other hospitals to receive their care. There were 11 transfers for 16-17 years olds during this period.
- On the paediatric unit beds were not permitted to be closed to GP admissions. This meant that even when the escalation policy had been followed, the ward would not be fully closed.
- The service achieved the national referral to treatment target between April and November 2015 within the paediatric specialities. However, from December 2015 – February 2016, 98 clinics were cancelled.
- Community nurses attended the paediatric ward each day to help discharge children who could be cared for in the community.
- The trust had a 'Gateway' triage system in place for most GP referrals (excluding cancer referral), which had been set up by the local commissioning groups. GPs referred children directly to the service, where a team assessed referrals and signposted children to the correct services within the hospital or provided them with advice.
- The trust had a guideline for admission of children aged 16 to 18 years to adult wards. This clearly set out the procedures and expectations for staff for these admissions.
- Open visiting was available to parent with children on the paediatric and neonatal units.
- NICE guidance requires transition pathways to be in place. With the exception of diabetes, and neuro-disability, transition arrangements were not in place within paediatrics. However, the trust did recognise that it required significant improvement in this area and had recorded on the paediatric improvement plan that on 29 February 2016 they would begin to address this need going forwards.

Meeting people's individual needs

- Parents explained that they were been given information leaflets advising them how to care for their child's particular medical condition. During our inspection we observed this taking place.
- A play service was provided from 9:00 – 17:00 Monday-Friday. The ward had a play room, a teenager's room and a sensory room. Each morning that play leads worked the play leads set up activities in the middle of bays suitable for the children in each area. Children in cubicles were also given activities to do.
- The trust told us they were currently working to create an introductory video for parents and children coming to the paediatric ward to explain basic housekeeping, where everything was and how the unit works. We were told this to improve patient experience and reduce the time nursing staff spent doing this.
- In response to negative feedback in the friends and family test, the trust implemented an empathy training video which formed part of nursing and medical mandatory training.
- CAMHS children were referred directly on to the ward. If they required 1:1 nursing, this was requested from bank or agency staff.
- Staff told us that children with complex needs had to attend different appointments so their needs could be addressed.
- The service had a varied range of language translators available within the trust. If a translator could not be available in person, translation services were provided by a telephone service. However, there were no signage or leaflets available in additional languages. This meant the service did not address the needs presented by the diversity of the local population.
- Whilst consultants had job plans, these did not meet the requirements of the facing the future standards as they did not address provision of consultant cover at peak times.
- The service had a sensory room for children with learning disabilities.
- Staff at the hospital were participating in a study with Salford to improve communication for people with learning disabilities. This involved staff learning sign language so they can begin to communicate more effectively.
- In MDT handover meetings individual needs were discussed and individual discharge arrangements in detail to ensure all staff were aware of plans.
- On the neonatal unit, there were no toys in the family waiting area. The ward manager explained that this was due to the time it took to clean the toys. Siblings were provided with a colouring book and crayons that they could take home.
- Theatres used for paediatric surgery had a dedicated child friendly reception and recovery area.
- The trust told us parents with children receiving longer term care were provided with free on-site car parking.

Services for children and young people

- The Children and Young People's Experience Group helped develop a 'signalong' campaign with assistance from Salford University. All members of staff were taught one new sign per month.
- Neonatal parents had set up a Supporting Parents of Oldham and North Manchester Neonates group which met weekly at the trust.

Learning from complaints and concerns

- At the time of our inspection the trust had just produced its first trend analysis document for complaints and incidents in the Women and Children's division. This report identified the main themes of delay, staff attitude and communication.
- Two serious incidents were notified to Steis following receipt of complaints. Investigations were protracted resulting in delayed responses.
- Actions on action plans following complaints were not consistently acted on when serious incidents resulted from complaints.
- Ward managers were aware of complaint trends. However, there was no action plan in place to address the recommendations.
- In the division 69% of complaints were upheld or partially upheld.

Are services for children and young people well-led?

Inadequate

Overall in terms of being well-led, we judged that the neonatal and paediatric services at North Manchester General Hospital were inadequate.

- There was significant concern regarding how well led the service was. The delivery of high quality care was not assured by the leadership, governance or culture in place.
- There was no strategy within the service. The paediatric team were following the paediatric improvement plan, however there was no strategy for continuous improvement or sustaining changes resulting from it.
- Most staff were unaware of the trust's wider vision and mission.
- Senior nurses and managers did not have a robust overview of the performance of risks relating to the service, which had resulted in limited identification or escalation of risks to corporate level.
- There was not an effective system in place for identification and management of risks at team, directorate or organisational level. Significant issues that threaten the safe and effective delivery of care were either not identified or inadequate action was taken to manage them.
- There was a divisional risk register that highlighted some but not all risks that were currently faced by the department. Staffing levels had been calculated but this did not always reflect the need of the department.
- The trust board was out of touch with what was happening at service delivery level. Quality and safety were not a top priority for the trust board and decisions were taken that impacted on patient safety. Meeting financial targets was seen as a priority at the expense of quality care provision.

Vision and strategy for this service

- There was no strategy in place at the time of our inspection. The trust had a long-term vision which they were working towards as part of a five year improvement plan.
- Nursing staff told us they were unclear on the vision and values.

Governance, risk management and quality measurement

- There was a Divisional Risk Register in place. However, we received five copies of the same document and all five registers contained different risks. We were not assured that managers within the trust were clear on current risks. From the documentation provided, it was unclear which risks were current and whether appropriate actions had been taken to address risks.
- There was no departmental risk register. As such, all risks within the service were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate them in the longer term.
- Managers were unable to articulate the risks on the risk register. Staff told us that the divisional risk register was circulated approximately four weeks prior to our inspection, prior to which they had not seen it.

- Senior staff told us that risks were added to the risk register and were not reviewed. This meant the risk registers were not dynamic. Risks contained on one of the risk registers went back to 2007. The lack of a comprehensive dynamic risk register meant the trust board did not have a complete overview of risks within the units or current mitigating factors that were in place. This meant they could not provide an appropriate level of executive scrutiny or the required response to mitigate risks in the longer term.
- Senior leaders within the trust did not give sufficient priority to ensuring there was learning from serious incidents. We reviewed serious incident investigations and found limited evidence that actions resulting from the investigations were addressed. An audit to review the management of serious incident investigation and sharing of learning was scheduled to take place in January 2016. At our inspection in February this had not taken place. This meant we had no assurance that the trust was giving this risk sufficient priority.
- In paediatrics there was a quarterly morbidity and mortality meeting where outcomes and lessons learnt in serious incidents were shared with medical staff. Nursing staff did not attend these meetings. Nursing staff told us they were unaware of the content of them, despite issues affecting nursing staff being discussed within them.
- The trust held monthly quality and performance meetings to address safety, clinical effectiveness, patient experience, performance and other divisional issues. The meetings are held at a trust wide level and again at departmental level. The departmental quality and performance meetings were held bi-monthly on the neonatal unit and quarterly on the paediatric unit. The trust told us that the minutes from the meetings were shared with all consultants, lead nurses and matrons for further dissemination.
- Quality and performance meetings were designed to oversee and assure the successful implementation of key quality and performance strategies including the assurance of quality and risk in a division. Nursing staff, their managers and medical staff's managers were aware that all incidents were not reported. They were also aware that risk assessments were not completed and there were no departmental risk registers. We reviewed meeting minutes. These issues do not appear to have escalated to the quality and performance meetings. In view of this, it is difficult to ascertain how effective/reflective these meetings actually were.
- Nursing staff, their managers and medical staff's managers were aware that all incidents were not reported. They were also aware that risk assessments were not completed and there were no departmental risk registers. We reviewed quality and performance meeting minutes. These issues were not recorded within these minutes. In view of this, it is difficult to ascertain how effective/reflective these meetings actually were.
- Neonatal services provided us with a detailed scheduled audit plan with dates for audits to be undertaken. This demonstrated evidence of effective workforce planning. We reviewed the recent audits that had been undertaken. Completed audits had recommendations and limited action plans that did not consistently address all the recommendations. Whilst action plans were included, it was not always clear when/if action plans had been completed.
- An audit plan was provided for paediatric services. This did not have planned dates for audits on it. This meant we had no assurance when/if audits had been undertaken and did not evidence how senior managers planned workloads nor had assurance that all audits would be completed within the timeframe. We discussed this with senior staff. They advised that the audits were scheduled. We requested the schedule, audits and action plans that have resulted from them but have not received them.
- The Trust performance in mortality reduction against other trusts nationally as shown in the Dr Foster Hospital Guide 2012 and through mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Indicator (SHMI) was shown to be deteriorating. The neonatal team recognised this and that efforts needed to be made to reverse this trend and ensure the drive to reduce avoidable deaths and avoidable harm. The neonatal team had monthly perinatal meetings where cases were discussed, actions were identified and learning was shared with paediatricians, obstetricians, neonatologists and trainees. Minutes from these meetings were shared with nursing staff, medical staff and multi-disciplinary team members by email and circulation of hard copies of the minutes.

- Neonatal staff attended a network clinical effectiveness group on a bi-monthly basis. Different topics are discussed throughout the network and best practice is shared.
- Quality and performance were monitored through the paediatric dashboard. This covered data such as sickness rates, new complaint, referral to treatment (RTT) rates and bed occupancy figures and additional information such as appointment cancellations and DNA (Did Not Attend) rates in the out children department.
- In paediatrics managers were aware that key staff within governance roles would be absent from the trust for a period of time. There was no continuity plan made for this resulting in a gap in paediatric governance for over four months. Paediatric governance was identified as a high risk in a meeting in December, but was not added to the risk register.
- The paediatric clinical lead told us that in winter additional funds were not made available to paediatrics to enable them to provide additional nursing staff on the ward. Nursing leads told us booking of nursing staff had proved more problematic recently as the trust had stopped using a local agency due to costs. However, following escalation of our concerns regarding staffing, the trust started reusing the local agency. We were not assured that sufficient priority was given to quality care provision at the expense of meeting financial targets prior to our inspection.
- Staff told us that incidents and complaints were not fed back on a regular basis following their investigation.
- At site meetings there was not a regular nursing presence. This meant nursing staff were not consistently aware of issues arising.

Leadership of service

- At Pennine Acute paediatric service the teams were led by the same core management team throughout the trust's hospitals down to Matron level for nursing staff and lead consultant for medical staff. In neonatal services the teams are led by the same core management team throughout the trust's hospitals down to Matron level for nursing staff and lead consultant for medical staff. Staff all told us that uniting the services offered within each hospital (Oldham and North Manchester) so they were cohesive and felt part of one organisation had proved challenging. Until early 2015 joint policies across all sites were not formulated. Staff reported that integration was improving, but they still felt separate to other locations within the trust. However, the locations had been merged for several years. The lack of integration impacted on learning being shared across sites.
- Staff told us that managers were visible on the ward. Staff said they felt they could address concerns with their immediate manager.
- Senior managers within the paediatric and neonatal service all expressed concerns regarding staffing levels within paediatrics and neonates for both medical and nursing positions. We were told that addressing staffing level issues to improve patient flow often felt like staff were 'firefighting' and took up a large amount (up to 90%) of manager's time. This then had a direct effect on the amount of time managers had to complete other management activities. Where roles were split between paediatric and neonatal management, paediatrics would take up 90% of individual's time, thus leaving the neonatal team with much less management support. Senior Managers told us they had made Directors aware of this situation.
- At the time of our inspection additional resource within senior management was reported to be imminent.
- Whilst consultants had job plans, these did not meet the requirements of the facing the future standards as they did not address provision of consultant cover at peak times.

Culture within the service

- We found a culture where staff were used to not reporting incidents. We were told that incident reports were not always completed as staff did not see the point in doing this as frequently there was often no feedback or action taken. In addition to this, a range of staff believed and reported that incident reporting was not their responsibility. This meant that the board and senior leaders would not always be aware of issues that the department faced.
- There was an acceptance from staff that provision of basic nursing needs was acceptable and the provision of additional care and that additional care for and interaction was not essential.
- Staff told us that historically, human resources issues were not managed in a timely way to ensure the right people were in the right job. Middle managers told us that action was not taken to address behaviour and

performance issues that were inconsistent with the vision and values. For example when performance issues occurred documented evidence had not been collated.

Public engagement

- The safeguarding team initiated a project with a local primary school looking at improving the services provided in line with children's needs. Children from the school were invited to the hospital for a day and answered several questions thy had created. They sent the hospital feedback on how service provision could be improved. The children also interviewed the trust board about their concerns. The trust were in the process of implementing the recommendations that were made.
- The trust had introduced a text messaging service to obtain patient feedback.
- In the parents room the staff had introduced a board providing information. They asked parents for feedback on their understanding and amended things accordingly.
- The trust were trialling a text messaging feedback service in order to improve the level of response they receive regarding the services they provide. At the time of our inspection staff were investigating ways to increase uptake of this.
- The trust did not have an inpatient survey. They had an open and honest board where children/carers could leave their feedback.
- The NHS Friends and Family Test was not undertaken on the neonatal unit. However, comment cards were available for provision of feedback.

Staff engagement

- The trust had improvement plan meetings that were open to staff of all grades. Those who attended told us they were a "safe" place to discuss issues and found them useful. The meeting place was alternated between this hospital site and Royal Oldham hospital to allow for easy access for staff. However, staff told us due to pressures on the ward, it was not always easy to attend the meetings.
- Ward meetings were planned monthly.

Innovation, improvement and sustainability

- On the neonatal unit, managers were aware that two ANNP nurses were retiring. No succession planning had taken place to ensure service continuity. However, at the time of our inspection the trust had recruited two people to train, as ANNP's but their training will not be complete until the end of the year.

End of life care

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

Information about the service

The trust specialist palliative and end of life care service is part of the out of hospitals directorate within the integrated and community services division of the Pennine Acute Hospitals NHS Trust. The service operates across four hospital sites (Fairfield General Hospital, North Manchester General Hospital, Rochdale Infirmary and Royal Oldham Hospital) and in the community in North Manchester. The service operates from Monday to Friday, 8.30am to 4.30pm.

The service aims to help patients and families live as well as possible by providing pain and symptom control, in addition to specialist psychological, emotional, social and spiritual input as appropriate. The service supports patients with life- limiting illnesses and is based on a multi-disciplinary model of care, working closely with different disciplines and specialties within the trust and in the local community. Patients receiving input from the service are usually within the last 12 months of their lives.

There are no dedicated EOLC beds at the trust. Between April 2014 and March 2015 there were 820 deaths at the hospital, an average of 68 per month. Figures to date this year are similar, with an average of 67 per month between April 2015 and February 2016.

There is no hospice in Manchester however the specialist palliative care (SPC) team have close links with St Ann's hospice in Little Hulton, Dr Kershaw's hospice in Oldham and Springhill hospice in Rochdale.

There are no post mortems conducted at the mortuary at North Manchester General Hospital (NMGH) however the technicians do remove pace makers and other medical devices. They facilitate viewings and are regulated by the Human Tissue Authority. Routine post mortems for NMGH patients are carried out at the Manchester Royal Infirmary (MRI) and home office and forensic post mortems are conducted at the Royal Oldham Hospital.

On the 24 February we met with the lead clinician for specialist palliative and end of life care (EOLC), the Macmillan associate lead cancer and palliative care nurse and an EOLC facilitator to gain an overview of the palliative and EOL service. In addition to the SPC team, generalist EOLC within NMGH is provided by ward teams and departments, and cancer and non cancer nurse specialists. We observed the weekly SPC multidisciplinary team meeting.

We visited eight wards at North Manchester General Hospital (NMGH): E1 (rehabilitation), E3 (general medicine), F4 (female medical), F5 (general surgery), I5 (trauma and orthopaedics), J3 and J4 (infectious diseases) and J6 (general medicine). We also visited the mortuary, prayer rooms and general office.

We observed care, looked at records for eight people, seven prescription charts and spoke with 5 relatives, 5 patients and 32 staff across all disciplines, including doctors, nurses and health care professionals. We spoke with members of the management team, the portering team, chaplains, bereavement officers, and mortuary staff.

End of life care

Summary of findings

Overal we Judged the service as Good. We found that there were good end of life (EOL) services across four domains Safe, Caring, Responsive and Well Led. The Effective domain was judged as Requiring Improvement

- Incident reporting systems were in place and learning from incidents was discussed locally at monthly ward meetings and at the safety huddles following handover. There had been no recent serious incidents related to end of life care (EOLC).
- We saw assessment information from occupational therapy and physiotherapy and good comprehensive nursing assessments in the records. Appropriate risk assessments were in place.
- The service had developed an individual plan of care and support for the dying person (IPOC) to guide care and support documentation in the last days of life in line with current evidence-based guidance and best practice.
- There was an audit plan in place and the reports we saw included appropriate recommendations and action plans to address the delivery of care where standards were not met. The hospital participated in the national care of the dying audit for hospitals (NCDAH). An action plan was in place from the previous audit in 2014, and some actions had been identified from themes picked up during the data collection process for the most recent NCDAH audit due to be published in March 2016.
- The service held a weekly multi-disciplinary team (MDT) meeting where cases and new referrals were discussed. Representation from a wide number of different disciplines attended and we saw evidence of good collaborative working across the different agencies and teams.
- End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. Ward, mortuary and portering staff were respectful and caring when they spoke about their patients who were at the end of life. There was opening visiting throughout the trust. The service had introduced the butterfly symbol to promote privacy and dignity for patients and families, and enable staff to respond accordingly.
- We saw evidence that people's individual needs were being considered at end of life and that discussions with patients and their families were taking place. Referrals to the SPC team were priority rated and ward staff told us the SPC team responded quickly to requests for their input.
- Staff were conscious of environmental constraints on the Nightingale style wards and offered side rooms or quieter beds at the end of the ward where possible.
- There were numerous new systems in place or in planning to improve the provision of EOLC including the new steering group, the new reporting operational policy and the proposals for a new bereavement service, seven day working and an electronic palliative care co-ordination system (EPaCCs). Staff were encouraged to use information to make improvements based on feedback from service users, audit results and incident reports.

However

- The rapid transfer process was in its infancy and the service was taking steps to put improvements in place. There was no clear policy that defined the different rapid discharge processes with targets for the time taken.Some patients were not prescribed all of the recommended anticipatory end of life medications. EOLC training for doctors was in place to address this.
- There was no seven day service in place and although the potential risks of the impact on patients had been identified, assurance around the management of these risks was not clear.
- Although the IPOC had been disseminated to the wards and trainers on each ward had been identified, uptake was slow. The service, with support from very senior managers, should consider developing a plan to embed its use.
- Completion of uDNACPR documentation consistently failed to meet the required standards. Plans to address this included a formal audit in April-may 2016 and the appointment of a DNACPR facilitator to educate and train staff.

End of life care

Are end of life care services safe?

Good

There were systems in place across the service for reporting incidents and staff knew how to access these. Learning from incidents was discussed locally at monthly ward meetings and at the safety huddles following handover. The service was pro-active in using a number of different systems to improve the identification and reporting of safety concerns, incidents and near misses, for example introducing key words to the reporting systems and conducting significant event analysis (SEA) meetings. Actions were put in place following these meetings.

There were organisational structures in place to support the management of EOL medicines and new guidance in line with the latest recommendations from the strategic clinical network had been drawn up. Prescribed anticipatory medicines were administered where applicable and we saw evidence of medication reviews with inappropriate medications discontinued. Record keeping was generally good, with comprehensive nursing assessments in place.

We saw consideration given to safeguarding concerns. The SPC team were up to date with their mandatory training which included safeguarding level 2 and advanced communication skills. EOLC training was mandatory for new healthcare assistants as part of the care certification, and an annual session was delivered to nursing cadets.

EOLC care was the responsibility of all the staff and not restricted to the SPC team. The SPC team had a whole time equivalent (WTE) of 3 nurses in the hospital and a trust-wide lead nurse, and they visited the wards to offer support and guidance when requested. There was a full time consultant in palliative medicine.

Risks to disruption to the service, for example the mortuary reaching capacity, were planned for and managed effectively. Staff understood their role and plans were tested.

Learning from incidents had not always been as effective as it could have been and this was being addressed by the new EOLC steering group which had implemented new ways to identify incidents related to palliative care and EOLC.

End of life care

Some patients were not prescribed all of the recommended anticipatory end of life medications. This meant that if a patient started to experience new or worsening symptoms outside doctors' normal working hours there could be a delay in administering the appropriate medication. EOLC training for doctors was in place to address this.

Incidents

- There were systems and processes in place to report incidents and staff told us they were encouraged to do so.
- Ward staff knew how to report incidents and were able to provide examples of incidents that related specifically to palliative care or EOLC, and what the outcome had been.
- We reviewed a selection of incidents related to EOL services and saw that follow up emails had been sent to the relevant staff for investigation, however confirmation that learning had occurred was not always evident.
- Information provided by the trust showed there were occasions where the same issue had arisen repeatedly, indicating the problem not been addressed adequately the first time an incident was reported. We discussed examples of these at a meeting with the service leads who were aware of this, and had introduced measures to improve lessons learned from incidents.
- This included the provision of selected key words identified by the SPC team to be included in the incident reporting system, allowing reports to be run for incidents where these words were mentioned. This was a new development so we did not see it in operation but the plan was for the information to be reported at the new palliative and EOLC steering group where common themes could be picked up for education purposes, updating guidelines and disseminating lessons learned.
- Feedback and learning from incidents was discussed at the monthly ward meetings. If immediate discussions with staff were necessary, managers would undertake these and carry out any required investigations. The manager on J3 explained that the team would go through route cause analyses (RCAs) from incidents point by point at these meetings and any staff not present were required to sign a sheet to indicate they had read the minutes.
- There were safety huddles at the end of every handover when discussions around safety issues would take place. Staff gave examples such as any concerns regarding relatives on the ward, infection control issues or incidents. Recently staff had discussed how to lessen interruptions during a drugs round to lessen the chance of medication errors.
- Lessons learned from incidents were included in a quarterly bulletin disseminated throughout the trust and available to all staff, monthly medical education bulletins and the Monday message delivered electronically from the chief executive.
- The Transform programme (detailed later in the report) included regular significant event analysis (SEA) meetings where staff were given the opportunity to reflect on and discuss recent EOLC experiences on the ward with actions taken forward when identified. We saw evidence of these in a SEA issues and actions table provided by the trust.

Medicines

- Medical staff at NMGH had access to an electronic prescribing and medicines administration system. Within this system was a palliative bundle, with information about anticipatory prescribing and algorithms for guidance.
- Recommendations (NICE guidelines CG140, QS13 and Gold Standard Framework 'Just in Case' good practice) for the prescription of anticipatory medicines suggest that patients often experience new or worsening symptoms outside doctors' normal working hours so medicines should be prescribed for the alleviation of pain and shortness of breath, nausea and vomiting, agitation and respiratory secretions. We reviewed prescription charts for seven EOL patients. Three patients had not been prescribed all of the recommended anticipatory medication. We returned and reviewed one of these charts 24 hours later, but the anticipatory medicine prescriptions were still not in place.
- The anticipatory medicines that were prescribed were administered where applicable and there was evidence of medication reviews with inappropriate medications discontinued.
- The hospital achieved the organisational key performance indicator (KPI) in the May 2014 national care of the dying audit of clinical protocols for the prescription of medications for the five key symptoms at

the end of life (KPI 5). However, the percentage achieved for clinical KPI 5, medication prescribed prn for the five key symptoms that may develop during the dying phase was slightly lower (worse) than the national average. This suggested that the organisational protocols were in place, but in practice the case note review showed these protocols were not always being adhered to. The KPI was met in 47% of cases and the national average was 50%.

- Reluctance to prescribe anticipatory end of life medications as per prescribing guidance had been identified as part of a significant event analysis (SEA) in the Transform programme. Actions identified to address this included the SPC team attending the grand round and planned teaching sessions for the junior doctors to raise the issues identified.
- New pain and symptom control guidelines had been adapted from the latest strategic clinical network guidance. These included pain and symptom control in EOLC, fentanyl guidelines and syringe driver guidelines. At the time of our inspection they were in the final stages of development, awaiting ratification.
- The service used the recommended syringe driver which is a small portable battery operated infusion device for administering medication, particularly for symptom control at EOL. Syringe drivers could be ordered by staff from the electro-biomedical engineering (EBME) department medical equipment library. Porters had access to this out of hours and would collect a syringe driver when requested, and complete the necessary log.
- Care plan templates for the syringe drivers and EOL analgesia were available on the trust intranet in the nursing documentation.

Records

- Most patient records were in paper format and were integrated with medical and nursing staff entries recorded together, chronologically.
- There was an electronic 'patient centre' where certain information was recorded, such as estimated discharge dates, and alerts for oncology patients and those with infection control concerns.
- We looked at eight sets of care records and found record keeping to be mostly good with some gaps, for example with uDNACPR documentation as detailed later in the report. We saw evidence of good documentation regarding mouth care, skin care and clear discharge planning.
- We saw assessment information from occupational therapy and physiotherapy and good comprehensive nursing assessments covering information about personal hygiene, mobility and pain as well as psychological and cognitive considerations including issues and concerns.
- There were risk assessments for venous thromboembolism (VTE), pressure ulcers, falls and moving and handling of the patient.
- Appropriate care plans were completed and reviewed.
- We saw one individual plan of care and support for the dying person (IPOC) in place which included information about the patient's anxieties and a plan for how staff were going to support the patient and family.
- There was a patient register in the mortuary where doctors signed when they completed cremation forms. There was also a doctors log where records showed which doctors had been to the mortuary, and at what time.

Safeguarding

- Information provided by the trust showed the SPC nursing staff and the clinical lead were up to date with safeguarding adults level 2 and safeguarding children level 2 training.
- We saw evidence that safeguarding concerns were considered, including a discussion at the weekly MDT with actions put in place.
- Staff knew how to contact the named nurse: safeguarding adults, and regularly did so.

Mandatory training

- Information provided by the trust showed the SPC nursing staff and the clinical lead were up to date with all mandatory training. This included moving and handling patients, information governance, infection prevention, health, safety and welfare level 1, hand hygiene, fire awareness, equality and human rights tier 2 and clinical waste segregation.

End of life care

- All clinical established members of the service had completed their advanced communication skills training as a requirement for peer review.
- The care certificate is the new minimum standards that should be covered as part of induction training of new care workers including health care assistants (HCAs). The mandatory care certificate training programme took place every month to coincide with recruitment of new HCAs who spent the first week of employment with the trust in the classroom learning both theoretical and practical skills. The SPC team delivered a comprehensive session on this training which covered EOLC including the significance of the butterfly symbol. We saw positive evaluations from all 15 staff who attended the January 2016 session which was described as informative, interesting and well delivered.
- There was also an annual session on the cadets training.
- Training on EOLC was delivered by the SPC team as detailed later on in this report. The team had liaised with the learning and organisational development department and there was no scope to have end of life care training included in the mandatory training portfolio.

Assessing and responding to patient risk

- We saw physiological observation charts (early warning scores) still in place for patients at the end of life. Early warning indicators were regularly checked and assessed.
- We saw one patient's documentation which had been transferred to an IPOC when it was recognised the patient was expected to die within days or hours.
- Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.

Nursing staffing

- The SPC nursing team was managed by the Macmillan associate lead cancer and palliative care nurse. The manager took responsibility for all aspects of operational management of the hospital Service.
- There were two full time band 7 specialist palliative care nurses with a band 6 due to start in the near future.
- The team also included an administrator and an EOLC facilitator based at the Royal Oldham hospital, who came to NMGH up to two and a half days per week.

Medical staffing

- The SPC team was clinically led by a full time consultant in palliative medicine. The consultant had 12 programmed activities (PAs) per week, each having a timetabled value of four hours. Five of these were allocated to medical education with seven for palliative care.
- He took referrals from the SPC team based on the complexity of their needs and worked together in an advisory capacity with consultants in other specialities.

Major incident awareness and training

- There was room in the mortuary for 34 bodies. When the mortuary reached capacity, bodies were transferred to Fairfield General Hospital mortuary which held 122 bodies. Staff were familiar with the processes involved in facilitating this.
- Major incident plans were centralised via Fairfield hospital.
- There was an electronic system in place which monitored the temperatures of the fridges in the mortuary which were checked and logged twice daily in a book. If the fridge temperatures deviated from the defined range an alarm sounded. If the mortuary was not staffed emails were automatically sent to the switchboard who would contact the porters on call to go and check the equipment. The porters would call estates if necessary. If problems continued the bodies would be transferred to Fairfield General Hospital.

Are end of life care services effective?

Requires improvement

There was no seven day service in place and although the potential risks of the impact on patients had been identified, assurance around the management of these risks was not clear. There were plans to pilot a modified seven day service including acute oncology representation in 2016.

End of life care

The service had developed an individual plan of care and support for the dying person (IPOC) to guide care and support documentation in the last days of life in line with current evidence-based guidance and best practice. IPOC had been disseminated to the wards and trainers on each ward had been identified, uptake was slow. The service, with support from very senior managers, should consider developing a plan to embed its use. The introduction of many recent changes meant that introducing further initiatives such as the amber care bundle and advanced care planning documentation was not feasible until the IPOC was more widely used. However, staff were familiar with the principles of these documents and we saw evidence that discussions were being held with families and patients to plan care and make decisions.

Staff were aware of processes around capacity assessments and Deprivation of Liberty Safeguards (DoLS) and who to contact for guidance and support. Completion of uDNACPR documentation did not always meet the required standards. Plans to address this included a formal audit in April-May 2016 and the appointment of a DNACPR facilitator to educate and train staff.

People had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Audit results for standards related to nutrition and hydration needs had been poor, but the recent introduction of the MUST tool meant nutrition assessments were evident in the records we reviewed.

There was an audit plan in place and the reports we saw included appropriate recommendations and action plans to address the delivery of care where standards were not met. The hospital participated in the national care of the dying audit for hospitals (NCDAH). An action plan was in place from the previous audit in 2014, and some actions had been identified from themes picked up during the data collection process for the most recent NCDAH audit due to be published in 2016.

The SPC team staff had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training content was regularly revised to incorporate changes required for different staff groups or to incorporate themes for learning identified from incidents and audits.

The service held a weekly multi-disciplinary team (MDT) meeting where cases and new referrals were discussed. Representation from a wide number of different disciplines attended and we saw evidence of good collaborative working across the different agencies and teams.

Evidence-based care and treatment

- The service had adapted an individual plan of care and support for the dying person (IPOC), originally developed by the Greater Manchester, Lancashire and South Cumbria strategic clinical network palliative and end of life care working group. This was designed to guide care and support documentation in the last days of life, and included the priorities for care in the last days and hours of life as set out by the NHS England Leadership Alliance for the Care of Dying People.
- The IPOC included information and prompts regarding food and drink, symptom control, psychological, social and spiritual support and was used to record the individualised tailored care delivered to the dying person in the last days and hours of their lives and support their families, carers and those close to them.
- A patient and family communication diary was used alongside the IPOC. This was left at the patient's bedside for relatives or family members to communicate with staff or write memories in. It was intended as a way to try and break down potential barriers to communication.
- The IPOC was not widely in use on the wards we visited. We were told one patient at the end of life was to be put onto the plan but we returned to the ward the following day and this had not happened. No reason for this was documented in the case notes.
- We asked staff why the IPOC was not in use and were given a number of different reasons including staffing issues, and a feeling of being 'overwhelmed' with a large number of new initiatives to embed in practice. Other new documentation such as the Malnutrition Universal Screening Tool (MUST) and Fall Safe had been introduced, and there was some uncertainty around the appropriate time to commence a patient on the IPOC. One staff member explained that if they made the decision too early, it could be distressing for relatives who would think their patient was at the end of life, but if it was too late, there was little point as there would be no time for the benefits of it to be realised.

End of life care

- There was a standard operating procedure in place for the spiritual care team, detailing the role for chaplains on the ecumenical on call rota to complete the spiritual care elements for patients on the IPOC. The chaplaincy team described 'resistance from medical staff' to the IPOC and said despite two pilots in 12 months, there was no uptake of the plan. Meeting minutes from the September 2015 EOLC steering group documented high levels of frustration in the chaplaincy team who had suggested education for medical staff and some 'top down' influence to help overcome barriers to completing the documentation.
- The medical staff we spoke with on the wards said they had received no training on the IPOC. However, training was available for medical staff, but not mandatory. Meeting minutes from the January 2016 EOLC steering group documented an agreement for the medical director to send out information regarding the IPOC to senior medical staff, in order to increase awareness.
- There was an audit plan in place as part of the Transform programme which included pre, interim and post programme audits for staff skills, knowledge and confidence, case note reviews and four hourly mortuary transfer times. The plan also included an annual record keeping audit. We saw the completed record keeping audit report from February 2016 which included recommendations and an action plan.
- A trust wide audit from 40 sets of case notes was undertaken in 2014 to provide a baseline position against the standard that all deceased persons should be transferred to the mortuary within 4 hours of death as per Hospice UK Guidelines (2015). Compliance with the target was 53%. An action plan following smart (specific, measurable, achievable, relevant and timely) principles was in place to address the issues identified.

Pain relief

- Pain scores were assessed using a numeric rating scale and we saw assessments and good documentation regarding pain in all eight sets of case notes reviewed.
- One patient had been seen by the pain service.
- A visual version pain assessment tool had just been developed for patients with cognitive impairment, however this was not yet being widely used as it was very new. Several different staff members mentioned this to us, indicating good awareness of the new tool.

Nutrition and hydration

- In the 2014 national care of the dying audit the hospital achieved a lower (worse) percentage than the national average for clinical KPI 7 which was completion of a review of the patient's nutritional requirements (25%) and for a review of the patient's hydration requirements (35%).
- Ward staff said the Malnutrition Universal Screening Tool (MUST) had been recently introduced and we saw evidence of this in the notes we reviewed. One set of case notes had no record charts completed but a family member was administering food and fluids.
- We saw an appropriate referral to the dietician. Speech and language therapists prioritised patients who needed a swallowing assessment so the MDT could decide the best way to ensure patients received adequate nutrition and hydration.
- A 2015 audit showed that compliance with two standards related to nutrition and hydration had dropped when compared to a baseline audit undertaken prior to the Transform programme in 2014. These were for the presence of documentation to indicate that hydration and nutrition had been discussed with the patient and/ or relative (41% compliance down to 10%) and evidence that the patient was supported to eat and drink (42% compliance down to 35%). We did not see evidence of an action plan to address this.
- Use of the IPOC for patients at the end of life would prompt staff to consider and document information related to the patient's risk of aspiration, whether the speech and language therapist or dietician needed to see the patient and the consideration of clinical assisted nutrition or hydration.

Patient outcomes

- In the May 2014 national care of the dying audit for hospitals (NCDAH) the hospital achieved four of the seven organisational key performance indicators (KPIs). These were access to information relating to death and dying (KPI 1), clinical protocols for the prescription of medications for the five key symptoms at the end of life (KPI 5), clinical provision/protocols promoting patient

privacy, dignity and respect, up to and including after the death of the patient (KPI 6) and formal feedback processes regarding bereaved relatives/friends views of care delivery (KPI 7).

- The organisational KPIs not achieved were access to specialist support for care in the last hours or days of life (KPI 2), care of the dying: continuing education, training and audit (KPI 3) and trust board representation and planning for care of the dying (KPI 4).
- For clinical KPIs the hospital scored lower (worse) than the national average for nine of the ten indicators. The exception was the indicator for a review of the number of assessments undertaken in the patient's last 24 hours of life (KPI 9) which scored 91%, better than the national average of 82%.
- An action plan was put in place following the NCDAH and we saw evidence that actions had been implemented or were in progress, such as the new training programme available to staff and the introduction of the IPOC.
- Performance for some elements from the clinical KPIs still appeared inconsistent, for example the prescription of anticipatory medication as detailed earlier in this report.
- Data collection had taken place for the most recent NCDAH due to be published later this year. Some of the themes identified by the service during data collection included lack of recognition that a patient was in the dying phase, lack of communication to carers during this time and poor documentation around care after death. These areas had been considered when revision of the education programme took place.
- The SPC team were in the process of engaging with the information management and technology department in relation to making some prognostic guidance around EOLC available on the intranet to help with identifying the point when people may have a life expectancy of one year or less. This would enable earlier discussion of patient wishes (advanced care planning) and improvements in care delivery aligned to patient preferences, including achieving preferred place of care and death. They were also producing some small pocket cards for clinical staff detailing the priorities for care and support for the dying person.
- The Transform programme aims to improve the quality of end of life care within acute hospitals across England, enabling more people to be supported to live and die well in their preferred place. Two wards at NMGH took part in this programme; H4 (cardiology) and J6 (general medicine). They completed a training programme covering the five key enablers (EPaCCS, advance care planning, rapid transfer, IPOC, and amber care bundle) and two hospice placement days. This was followed by 12 months of ward based teaching on the IPOC and support for the dying person, spiritual care and pain and symptom control.
- The amber care bundle is designed to facilitate discussion between staff, patients and families so that plans can be put in place which accommodate the patient's preferences and wishes when they may only have a few months left to live. The SPC team had discussed the implementation of the amber care bundle but there were no plans to introduce it until the IPOC was embedded.
- Similarly, the advance care plan was not yet in use, although information about its purpose was available for patients and carers. While there was no formal advance care plan in use, we saw evidence that discussions were being held with families and patients to plan care and make decisions.
- An audit of the Transform wards was undertaken in November 2015 to look at whether participation in the programme had improved EOLC. There were improvements in several areas and the recommendation was to embed the programme through trust policy. However, there were some areas where compliance had dropped, two of which are detailed in the nutrition and hydration section of this report.
- An action plan was in place for the second cohort of wards to embark on the Transform programme in 2016, with a third cohort in 2017.

Competent staff

- Both of the specialist palliative care nurses had completed a post registration degree in health and social care which included palliative care modules. Between them they had also completed English national board for nursing, midwifery and health visiting (ENB) teaching and palliative qualifications as well as quality improvement, non-medical prescribing and clinical examination skills.

- Information provided by the trust confirmed that appraisals were up to date and on target The consultant's input to the team was monitored through his clinical director and the trust's annual appraisal process.
- Training for the IPOC had been delivered by the SPC/ EOLC facilitator to an allocated cascade trainer or facilitator from each ward. These trainers had a resource file and the intention was for them to deliver the training to their ward teams, however this was not yet underway by the staff we spoke with. One staff member said she knew the theory around using the IPOC but would teach staff as and when required, once the document was in use.
- Since November 2015 a comprehensive palliative and EOLC rolling education programme had been delivered by the SPC team which included key topics such as identifying patients approaching EOL, priorities for care and support for the dying patient including emotional, spiritual and religious needs and communication in palliative care incorporating uDNACPR and rapid transfer. Palliative care emergencies, nutrition and hydration in palliative patients and pain and symptom control at the end of life were also covered. The topics were delivered within a module basis over two days three times a year rotating across the different hospital sites, but were not mandatory.
- There was a palliative and EOL link members one day programme held three times per year.
- The SPC team supported the consultant in palliative medicine to provide training to the foundation year doctors (FY1s and FY2s) on an annual basis. Sessions for the medical staff included information on coronial matters, death certification and cremations, and pain and symptom control for EOL patients. There were also ad hoc training sessions on palliative and EOLC for doctors, and presentations with questions and answer sessions at two grand rounds per year.
- We saw positive feedback from four FY2 training sessions in 2015, attended by 96 doctors. Training provided by the consultant in palliative medicine was described as informative and useful, and the consultant was described as engaging and entertaining. 100% of trainees felt more confident on the subject after receiving this teaching and the only two suggestions for improvement were from people who would have liked the training earlier in their programme.
- Training for ancillary staff had been piloted but not well attended. The SPC team recognised that this training needed to be more bespoke but said specific training requested by the porters following an incident had been delivered. Training content was regularly updated and revised to accommodate changing needs and incorporate themes for learning identified from incidents and audits.
- Sage and Thyme communication skills training was provided across the trust approximately six times per year to any staff who had patient contact. This was a three hour communication skills workshop designed to enable the delivery of psychological assessment and support through guiding staff to allow patients or carers to share their concerns, emotions and fears, explore their own solutions and ask for help if they wish.
- Training in the use of the McKinley syringe driver was available online with a self-assessment to complete when the training had been undertaken. Some staff also reported receiving training from the medical devices team. The SPC team provided further support around the use of consumables. Syringe driver training was not mandatory.

Multidisciplinary working

- The service held a weekly multi-disciplinary team (MDT) meeting where cases and new referrals were discussed. Representation from chaplaincy, occupational therapy, physiotherapy, speech and language therapy, pharmacy, psychiatry and the transfer of care team all attended on a regular basis, as did members of the community teams.
- We attended the weekly MDT with ten community staff and ten hospital staff from a variety of disciplines. We observed good joint working between services and comprehensive discussion of current patients including safeguarding issues.
- Referrals were made to the SPC team electronically, and they could also be contacted by telephone or bleep. If the team were out of the office on the wards, they could check any computer to assess and triage referrals. Referrals were checked throughout the day and entered onto the team's database at the appropriate level.

End of life care

- The SPC team described good access to the consultant in palliative medicine and good links with the consultants at Fairfield hospital and the North Manchester community team.
- A business case had been submitted to develop a clinical portal to support an electronic palliative care co-ordination system (EPaCCs) however this was not yet in place. The team were familiar with the requirements and were planning for possible future implementation by incorporating the data field requirements into their own database. This meant they were already starting to record and collect the type of data required when using an EPaCCS system.
- Other staff in the general office provided cover for the bereavement officer when she was on leave. They said the system worked well and they had good relationships with the doctors, the coroner's office and the registrar.

Seven-day services

- The SPC team and consultant in palliative medicine did not provide seven day cover at NMGH.
- EOLC resource folders had been produced and were available on all the wards. These included details of who to contact out of hours for advice. The community team was funded by MacMillan from 8am to 8pm seven days a week and between 8pm and 8am there was an advice line at the hospice.
- The consultant said although he was not on call out of hours he was flexible if there was a complex patient.
- The inability to provide seven day working due to inadequate staffing establishments had been risk assessed with the potential impact on palliative care out of hours patients detailed. This included the risk of increased length of stay, inappropriate admission, uncontrolled symptoms, reduction in the patient/carer experience, not dying in the preferred place and drug errors in relation to SPC prescribing.
- Actions identified to mitigate these risks included generic palliative care training for clinical teams and ensuring the delivery of pre-anticipatory planning and prescribing of medicines for patients known to the SPC team. There were no details provided as to how the team were assured these controls were working or how the team would ensure anticipatory planning and prescribing were in place.
- If a patient died out of hours and was from a faith where particular rituals are carried out within a short timeframe following death staff would contact the bleep holder for medicine for advice. A medical certificate of cause of death (MCCD) could be issued if the death did not need referring to the coroner and these were available for doctors at points around the hospital.
- A small allocated amount of multi professional education and training (MPET) funding had been secured and the service was hoping to pilot a modified seven day service including acute oncology representation in 2016. A meeting to discuss this was planned for March 2016. This pilot had previously been postponed due to limited availability of staff due to long term sickness and maternity leave.

Access to information

- When patients at the end of life were discharged an electronic palliative care handover form was completed to notify the GP if the SPC team had been involved in their care. This was also completed for palliative patients if there were complex needs. The medical staff on the ward also liaised with the GP when an EOL patient was discharged.
- Some information about EOLC was available on the intranet, with plans for more information such as prognostic guidance to be added.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Capacity assessments were usually completed by consultants if it was in relation to prescribing medication, or by the allocated social worker if it was in relation to discharge planning. Social workers were based with the patient flow team and saw patients dependant on the area they lived or the location of their GP.
- The rapid assessment interface and discharge (RAID) team would come to the ward when requested, to advise on patients with dementia or acute delirium.
- Referrals were made to the community mental health team (CMHT) who visited the ward for patients with mental health concerns.
- Staff were aware of processes for Deprivation of Liberty Safeguards (DoLS) and guidance and support around

these were provided by the named nurse: safeguarding adults, who was described as being very accessible. Staff we spoke with were aware of recent changes which meant that every patient on enhanced observation, ie one-to-one nursing (also called patient watch), who lacked capacity must have a DoLS in place.

- In the most recent national care of the dying audit for hospitals (NCDAH, 2014) results for the NMGH site service showed that discussions regarding the senior doctor's decision about cardiopulmonary resuscitation (CPR) were held with patients who were capable of participating in such discussions in only 35% (11) of the cases. This was lower than the national average of 41%.
- Annual DNACPR audits had identified some similar issues year on year. The 'do not attempt cardiopulmonary resuscitation' (DNACPR) form should clearly document any communication with the patient (or welfare attorney) or, if the decision has not been discussed with the patient or welfare attorney, the reason why should be clearly stated. Compliance at NMGH with this standard had steadily improved from 33% in 2011 to 79% in 2014, however the target of 100% was not close to being reached.
- Similarly the DNACPR form should clearly document any communication with relatives or friends. Compliance at NMGH with this standard had marginally improved from 48% in 2011 to 52% in 2014, but was nowhere near meeting the target of 100%.
- The service had identified continued issues with the completion of uDNACPR documentation. Minutes from the January 2016 EOLC steering group referred to four incidents including two where unified DNACPRs were put in place without any discussion with either the patient or their relatives. Actions taken included training for doctors' groups, an e-mail to all medical staff, a mini ward audit (16 wards, 59 uDNACPR forms) and consultant briefings. A formal uDNACPR audit was planned for April-May 2016.
- We reviewed seven uDNACPR documents. Of these, only two of six patients with a documented lack of capacity had assessments of patient capacity completed. No reasons why these assessments had not been undertaken were documented in the notes. Two patients did have capacity assessments and one patient had capacity therefore it was not necessary.
- There was evidence of discussion with family in all of the case notes, however the summary of communication with next of kin was not completed on the uDNACPR in three cases. This indicated that the communication was taking place, but the documentation was not always fully completed.
- The service was taking steps to address this as described above, and a band 7 DNACPR educator had been appointed and was due to come into post for 12 months from May 2016. Their role will be to educate and train staff, and encourage the wider staff group to be involved in the DNACPR process. They will also be expected to follow up from audits and identify areas of concern.

Are end of life care services caring?

Good

End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. Family members we spoke with were largely positive about the way they and their relatives were treated. Ward, mortuary and portering staff were respectful and caring when they spoke about their patients who were at the end of life.

There was opening visiting throughout the trust. The service had introduced the butterfly symbol to promote privacy and dignity for patients and families, and enable staff to respond accordingly.

Relatives could make an appointment with the registrar who attended the hospital every Wednesday which meant they did not have to go into Manchester to collect the MCCD.

There was no bereavement service which meant there was limited support for bereaved relatives and significant others. Some bereavement support was provided to families known to the SPC team and there was also a Macmillan information and support centre at NMGH.

There was a dedicated and proactive spiritual care team that provided emotional support regardless of faith, and religious care.

Compassionate care

- Feedback from a 2013 bereavement survey showed that it was not always possible to provide a peaceful setting for the dying patient and their family. The butterfly symbol has recently been introduced by the EOLC team for use throughout all wards to signify a patient was at the end of life. The symbol was used to promote privacy and dignity for patients and families and enable staff to respond accordingly.
- The use of the butterfly symbol was promoted extensively at training events, within trust wide publications and on a trust wide screensaver to ensure the maximum number of staff were aware of the symbol and its significance.
- A further bereavement survey was conducted in 2015 however there were only two returns for NMGH. This was discussed at the EOLC steering group in January 2016 where it was confirmed a new pilot will give every relative the option to fill in a bereavement survey to be included in a bereavement pack, with a pre-paid envelope for returns. Results from this will be collated by the service and identified themes will be addressed via education and training for specific areas. Positive feedback will also be passed on to the relevant team.
- There was an open visiting policy throughout the trust.
- There was a bereavement officer based in the general office between 8.30am and 4.30pm. She contacted the mortuary every morning for a handover regarding any overnight deaths. There was a whiteboard in the office with status updates for deaths referred to the coroner, inquests and post mortems.
- When a patient died the case notes were sent to the office and the bereavement officer bleeped the relevant doctor to come and complete the medical certificate of cause of death (MCCD). Junior doctors were released from other general ward duties to facilitate timely completion of the MCCD and there was an informal understanding that they would undertake this before 2.30pm.
- Relatives could make an appointment with the registrar who attended the hospital every Wednesday. This meant they did not have to go into Manchester to collect the MCCD.
- Portering staff used an electronic tablet Pennine porter request system (PPRS) to manage, allocate and update jobs requested by staff. Staff could view the status of the jobs booked and highlight any special requirements for the porter request. Porters used a red, amber, green (RAG) rating system to prioritise jobs such as transferring a body to the mortuary.
- Porters were very mindful of maintaining the privacy and dignity of the deceased patients. They would take the trolley for transporting the patient, but go on to the ward first, curtain off all the necessary areas and speak with staff before starting the transfer process. They were aware of the documentation and four forms of identification they needed to check. They were conversant with the booking in system at the mortuary and had a special security key for entry.
- The mortuary technicians managed viewings between 8am and 4pm but outside of these hours the porters would assist the nursing staff with these. Families could book a half hour appointment to attend the mortuary, where there was a viewing room with a sofa, plants and pictures on the wall.
- There was a viewing window which families could look through prior to entering the room but this was usually used for police identifications.

Understanding and involvement of patients and those close to them

- The service had produced a new information booklet explaining the purpose of advance care planning and this was available for patients. However, the actual advance care plan document was not in use.
- There was good evidence in the patient records of discussions with patients and families. There was documentation detailing patients' preferences and their concerns.
- One patient was married at the hospital during our inspection. The patient and family said the wedding was organised very quickly and they felt very supported.
- The patients we spoke with were mostly positive about nursing and medical staff, although they sometimes had to wait to be seen when staff were busy, particularly at night.
- One patient made a special mention of one of the medical staff who she described as "exceptional". She said he had provided her with everything she had asked for.
- Service members attended the monthly Pennine user partnership group (PPUP) on a rotational basis. This

provided a forum through which service users could contribute to the development of services within the trust. The service actively sought user input regarding patient information leaflets or service issues.

Emotional support

- There was no bereavement service which meant there was limited support for bereaved relatives and significant others. Some bereavement support was provided to families known to the SPC team and there was also a Macmillan information and support centre at NMGH.
- There was a spiritual care team that provided spiritual care, including emotional support regardless of faith, and religious care. The team was available 9am-5pm and there was a 24 hour on call service for out of hours emergencies and advice. There were also agreements with the Catholic church and representatives from the Muslim and Jewish faiths for the provision of chaplaincy services.
- Volunteers were available to work on the Transform wards when required. Day to day management was done at ward level and they met with the SPC and spiritual care teams for regular facilitated group supervision. Volunteers underwent training prior to taking up their role and once in post were able to carry out a range of tasks to support EOL patients including sitting with the dying person if they were alone or if their significant other/s requested a comfort break.

Are end of life care services responsive?

Good

We saw evidence that people's individual needs were being considered at end of life and that discussions with patients and their families were taking place.

Referrals to the SPC team were priority rated to receive the most appropriate response time based on need and ward staff told us the SPC team responded quickly to requests for their input. When a patient died, relatives were given the time they needed before transfer arrangements were implemented. There was good awareness of processes for deaths of people from different faiths.

Environmental factors meant that most of the wards were not ideal for EOL patients however staff were conscious of this and offered side rooms or quieter beds at the end of the ward where possible. There were no dedicated EOL beds but there was an infection control ward made up of entirely single rooms which offered some flexibility regarding moving patients to side rooms.

The rapid transfer process was in its infancy. The service was aware that improvements were needed to ensure that discharges were facilitated as quickly as possible, and was taking steps to put these in place. There was no clear policy that defined the different rapid discharge processes with targets for the time taken.

A range of prayer facilities was available although there were some environmental problems with the Muslim prayer rooms.

Service planning and delivery to meet the needs of local people

- Most of the wards at NMGH were single sex Nightingale wards, ie large dormitory style accommodation not subdivided into bays, although the wards we visited had at least one side room.
- Staff on different wards said they always offered EOL patients a side room where possible, but patients did not always want to be on their own, indeed at the time of our inspection there was an end of life patient on the main ward, where she had chosen to be. If patients chose to stay on the main ward they would be given a bed at the end of the ward which was more private.
- The infectious diseases wards, J3 and J4, were all side rooms. We visited J3 where two of their 14 rooms were allocated to respiratory conditions but the other 12 were regularly used for end of life patients who needed a side room. These included outliers from other wards where a patient wanted a side room but there was not one available.
- When outliers were admitted to the infection prevention wards they would be seen by the junior doctors on those wards, but consultant care remained the responsibility of the service the patient had been admitted under. There would also be involvement from the SPC team.

- One patient we spoke with said she had been moved several times, including in the middle of the night which she had found difficult.

Meeting people's individual needs

- There was evidence that people's individual needs were being considered at end of life. Of the eight sets of case notes we reviewed, seven had evidence or establishment of ceilings of care documented and all had evidence of discussion with family documented.
- There were no facilities for folding beds on the wards however family members could stay with their relatives at end of life if they wanted to use a chair next to the bed. On some wards there were sitting rooms or day rooms that could be used and on ward F4 there was an annex for the programme investigation unit (PIU) from where large recliner chairs could be borrowed over night for relatives to sleep on.
- There were facilities on the wards for families to access refreshments.
- Families visiting relatives at the end of life could apply for free parking vouchers from the service.
- Staff told us about four weddings they had organised on the wards in recent months and years, for patients who were at the end of life. They had clearly put a lot of time and effort into making these happen in order to meet the needs and wishes of the patients and their families.
- Information about rituals and cultural considerations for the different religions was available on the intranet, but staff we spoke with said they would find it useful to have more training about the different faiths. Guidance related to the orthodox Jewish way of life for healthcare professionals had been distributed to all wards.
- There was a Jewish mortuary on site, maintained and run by the Jewish community. Bodies could only be transferred to the Jewish mortuary after the MCCD had been issued.
- There were two Muslim prayer rooms at NMGH, one for females and one for males, two chapels and a room for use by those of Jewish faith which was well maintained by the Jewish community.
- St Raphael's chapel was used mostly by Catholics and St Luke's was used by all denominations; both were well maintained.
- There were some environmental problems with the Muslim prayer rooms. There were no signs directing people to the female prayer room which was very basic and had a problem with water leaks. There was a very loud, intrusive fan and the provision for ablutions was a hand basin in the toilet. The male prayer room was not signposted and difficult to find, however the facilities were better and included low sinks for ablutions.

Access and flow

- On average, 68 deaths per month occurred at NMGH, however not all of these were expected deaths or palliative patients, for example some occurred in accident and emergency.
- Information provided by the trust stated there were 907 referrals to the NMGH between 1 January 2015 and 31 January, 2016, ie an average of 70 per month which included cases where only telephone advice was required. This included referrals for patients who were discharged and did not die in hospital.
- The percentage of those patients recognised as being at the end of life who were referred to the SPC team was not known.
- Referrals to the SPC team were priority rated to receive the most appropriate response time based on need**.** The most urgent referrals required a one to two hour working day response time, either telephone contact or face to face. These included patients with severe pain or uncontrolled symptoms. Less urgent but complex referrals were expected to be seen within 24 hours and routine referrals, for example monitoring of an ongoing SPC management plan, within 48 hours. Ward staff said the SPC team responded quickly to referrals.
- All referral information was entered on to the SPC team's database. Information recorded on the database also included patient demographics, the consultant in charge of the patient's care, diagnosis, level of information and response time.
- There were two rapid discharge processes in place. One was the rapid transfer pathway, which referred to EOL patients under the care of the SPC team who wished to leave hospital to their preferred place of care. The second was the rapid discharge process which referred specifically to patients entitled to NHS continuing healthcare (CHC) and this was managed via the discharge team (also known as the transfer of care team). These patients were often palliative but not

necessarily at the end of life. The two terms were used inter-changeably by staff and in documentation received from the trust which meant it was difficult to get a clear understanding of the processes.

- We received conflicting information about the speed of both processes. The SPC team operational policy stated the service did not arrange discharge planning except for complex rapid discharge for end of life care (within 24 hours), however it did not identify 24 hours as a target. Where possible, ie if it was not a weekend or bank holiday, the SPC team facilitated the management and control of symptoms, and supported and prepared the family for caring for their relative at home.
- We spoke with two members of the discharge team who explained they each had allocated wards which they visited on a daily basis so they would already be aware of potential rapid discharges before the process began. The discharge team were only involved if the patient needed CHC and these patients needed to be clinically approved by the funded community nursing care team for fast track funding.
- The discharge team said they could discharge patients in 24 hours, and that this had happened last week, but delays could be caused by a wait for equipment needed at the patient's home, or by other services needing to be involved, for example occupational therapy.
- Ward staff described a rapid discharge as taking a minimum of 48-72 hours. One ward described the CHC fast track system as '"poor" and there was no fast track team on site for Bury residents.
- The SPC team explained the rapid transfer process had been piloted at Oldham where it was now embedded, but there was a phased approach and NMGH were not yet at the same stage.
- The strategy for palliative and EOLC included a work plan agreed and monitored via the palliative and EOLC steering group. This detailed a review of the rapid transfer pathway to be completed by March 2016, to identify gaps in provision, 'blocks' experienced and liaison with community and social care partners. The aim was to improve the process for rapidly discharging EOL patients to their preferred place of care with the sought outcome being an increase in the number of patients achieving their preferred place of care and death.
- The SPC team had started to monitor this outcome and provided documentation to us which showed for the period of 1 February 2015 to 31 January 2016 they had recorded the preferred place of care for 36% (651) of 1817 recorded deaths. Of these, approximately 50% (323) had died in their preferred place. We were unable to ascertain which sites were included in these figures.
- Minutes from the EOLC steering group meeting in January documented that robust rapid transfer data recording was needed and there was a plan for that to be co-ordinated through the group with a quarterly report to be developed.
- Staff told us pharmacy prioritised anticipatory medication when identified it was needed for rapid discharge, and that an agreement was in place with North West Ambulance Service (NWAS) for them to attend within two hours.
- When a patient died in hospital, the ward staff informed the family if they were not already there. The family would be allowed time with their relative and would be offered drinks and support. They would usually be invited to a private room on the ward to be given information about the bereavement officer and the process of obtaining the medical certificate of cause of death (MCCD).
- Staff demonstrated a good awareness of the different considerations when a patient was of a faith other than the Christian belief. An action from the November EOLC steering group log was to invite Jewish and Muslim representation to future steering groups.

Learning from complaints and concerns

- Complaints regarding EOLC were dealt with in the specialty the patient had been admitted under and therefore the SPC team and clinical lead were not always aware of them. In future, these will be within the remit of the EOLC steering group which should enable a better awareness for the service, of any issues or concerns raised by patients or their families.

Are end of life care services well-led?

Good

There was a strategy in place for palliative and EOLC (incorporating bereavement service development) and the

SPC team were clear about their vision and what they wanted to achieve. There were plans to help move forward the implementation of IPOC by including its use in the new ward accreditation scheme.

There were leads for EOLC at trust board level and a new EOLC steering group with oversight of incidents, complaints and audit results. There was a process for assessing risk but it was not clear from the information provided whether all of the risks were on one risk register in the integrated and community services division.

There was a focus on continuous learning and improvement of the service. There were numerous new systems in place or in planning to improve the provision of EOLC including the new steering group, the new reporting operational policy and the proposals for a new bereavement service, seven day working and an electronic palliative care co-ordination system (EPaCCs). Staff were encouraged to use information to make improvements based on feedback from service users, audit results and incident reports.

Vision and strategy for this service

- There was a strategy in place for palliative and EOL care (incorporating bereavement service development). The strategy defined the provision of palliative, EOL and bereavement care as everybody's business and responsibility from individual staff members in clinical areas, to senior executives on the trust board.
- The vision, values and strategy were developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service and staff. Focus groups were held at three of the trust sites in October 2015 and attendees were asked for their views on their experiences of end of life care in the hospital setting, and on what support, information and educational needs people would like. These were used to inform development of the strategy.
- The SPC team were conversant with recent palliative and EOLC publications and guidance and were tailoring their service to comply with these. At the time of our inspection many of these changes were ongoing and not yet embedded but the team had a clear vision of their direction.
- The trust had a transformation map detailing its vision, strategic goals and corporate priorities and these included the implementation in 2016 of a ward accreditation scheme. This scheme would look at a range of processes and activities on the wards which would be accredited dependent on how the ward performed.
- Some EOLC elements were to be incorporated in the scheme, including staff knowledge and use of the butterfly symbol for EOL patients, awareness of the rapid transfer process, ward implementation of the IPOC and completion of the associated e-learning and having an EOL link nurse in place. Credit on the scheme would be given for wards scoring positively in those areas which it was hoped would motivate staff to embed these new initiatives for EOLC.
- The trust board member with responsibility for EOLC was the chief nurse and the identified lay member was part of the EOLC steering group. A non-executive director representing EOLC was identified in December 2015.

Governance, risk management and quality measurement

- The new quarterly EOLC steering group monitored complaints, incidents, patient advice and liaison service (PALS) contacts and compliments which related to palliative, EOL and bereavement care. Work was being undertaken to improve the quality and coverage of collection of such data, for example the introduction of key words in incident reporting as mentioned earlier in this report.
- Risks regarding delivery of palliative, EOL and bereavement care were monitored by the EOLC steering group, and identified risks were presented to the division of integrated and community services quality and performance committee.
- Quarterly reports were submitted from the SPC to the EOLC steering group and the division of integrated and community services quality and performance committee.
- A bi-monthly SPC clinical governance meeting was held where all incidents and complaints relating to SPC were reviewed in order to identify any common themes and establish a co-ordinated action plan. All audit, service development and operational activity, statistics and

feedback were discussed. Quality and performance information and data were collected by individual teams and communicated within the service at the bi-monthly palliative and EOLC senior team, service and clinical governance meetings.

- A highlight report was sent annually to the corporate quality and performance committee. The trust board lay member with responsibility for palliative and EOLC was a member of this committee. The service also contributed information and data on its activity to the annual trust quality accounts, and produced a service annual report.
- The service provided a highlight report update in November 2015 for the safety committee. Risks identified in the report were the inability for sole delivery of the EOLC agenda and to meet the educational requirements of all health care professionals due to the small size of the team.
- There was a system in place for completing individual risk assessments and attributing them a score. All risks with a score of 15 or above were to be escalated to the central clinical governance department for consideration of inclusion on the strategic risk register.
- We saw risks reported in three different ways. Information provided by the service included risk reports for individual risks as well as two different risk assessment forms, one complete with risk reduction action plan. We saw a risk register for the out of hospital acute directorate which consisted of five risks, four of which related to palliative care.
- The individual risks we saw all appeared to be being managed appropriately however information on the assessments was not comprehensive in all cases, for example, on one risk assessment (for lack of seven day services) controls to mitigate the risk were documented but the section to detail assurance that the controls were working was left blank. This risk was not on the out of hospital acute directorate register.
- The mortuary was in the diagnostics and clinical support division and mortuary staff attended a monthly meeting which was always held at the Royal Oldham Hospital. Regular agenda items included updates from the coroner's office, staffing levels and governance issues including incidents. Minutes of the meetings were disseminated via email for staff who were unable to attend.

Leadership of service

- Palliative and EOLC delivery was under the executive ownership of the chief nurse. The EOLC steering group was formed in September 2015. This group was co-chaired by the lead clinician for specialist palliative and EOLC and the deputy chief nurse to reflect the need for executive level ownership of the strategy.
- There was a current operational policy in place for the SPC team, setting out the aims and objectives of the team, activity targets and operational details including governance.
- Staff in different areas said the chief nurse and deputy chief nurse were visible on the wards and had an 'open door' approach. Both had attended the opening day of a ward managers leadership development programme which had recently been launched at the trust. The chief nurse provided feedback to the wards when she received 'thank you' messages from patients or families.
- Senior management was described by staff as accessible. The quality matron was visible on the wards daily and one of the matrons for medicine went on to the medical wards every morning and was described as very approachable.

Culture within the service

- Ward staff said they felt well supported by the SPC team which provided a good service and responded promptly to referrals.
- The SPC team were positive about the service and had clearly worked hard to bring about the changes made so far.

Public engagement

- Members of the public were invited to attend focus groups held in October 2015 when the EOL strategy was being developed. The events were advertised by Healthwatch and took place across three of the trust sites including NMGH.
- Bereavement surveys had been carried out by the service and plans were in place to provide questionnaires to every bereaved family or relative in the future. This was being overseen by the EOLC steering group.

- The service had participated in the NCDAH and feedback from staff and patients had helped the service to improve the outcomes for patients.
- The public had online access to the minutes from the trust board meetings which provided information which may help the public understand about the hospital's performance.

Staff engagement

- Staff were able to participate in the focus groups mentioned above and were also invited to attend a 'listening into action' event where the idea for end of life care volunteers stemmed from.
- Throughout January 2016 workshops including information stands were held across all four trust sites to showcase best practice in EOLC. The aims included to hear patient and carers' experiences, launch the palliative and EOLC strategy and raise awareness of trust guidelines, policies, patient and carer leaflets and the education available to staff.
- The specialist palliative care nurses had completed post registration training and said they felt supported by the trust in their professional development.
- The discharge team nurses said it was rewarding to get people home and were very positive about their roles and the trust.

Innovation, improvement and sustainability

- The Pennine Porter Request System (PPRS) was an innovative new computer system used by the trust porters to manage the booking of porter services. Staff could book porter services through an online portal and the work was then allocated and updated by the porters while they were out on site, using their electronic tablet devices. Staff could check the status of the tasks they had booked online, which could be done in advance or marked as urgent. The PPRS was named the overall winner of the Innovation Award at the Health Estates and Facilities Management Association (HefmA) annual conference in 2015. The portering team said this system worked very well .
- A 'dying matters' week was planned across the trust in May 2016 promoting key messages about the importance of friends, family and loved ones talking with people towards the end of their life about their care or funeral, or making a will. The date for NMGH was 11 May 2016 when a display stand was planned showing information around EOLC at the trust and a display of artwork submitted for a competition held by the service. Artwork could be any form of handmade craft as long as it followed the brief of dying matters whether that interpretation is literally or emotionally. A similar event last year had been successful and this was a good way of promoting awareness around end of life care.
- A business case had been submitted for an integrated patient record system to enable transfer of information between key stakeholders. This would allow the delivery of an EPaCCS system.
- A 'gold standard' model of a bereavement service was to be used as a starting point to develop a business case. Bereavement services would hopefully then incorporate the spiritual care team, SPC team and bereavement officer separate to the general office facilities.

Outpatients and diagnostic imaging

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

Information about the service

The main out-patients department at North Manchester General Hospital (NMGH) was based in the newer part of the hospital with two clinics in standalone buildings in the hospital grounds.

The population attending the hospital have a lower life expectancy than the England average and 65% of the population of North Manchester live in the bottom 20% of deprived areas in England. The black, minority ethnic population is 40%. There were 242,462 outpatient appointments at NMGH from July 2014 to June 2015 and 701,767 for the trust overall.

There was a radiology department with computed tomography (CT) and magnetic resonance imaging (MRI) and an X ray department. The department also provided ultrasound (obstetric and non-obstetric), breast radiology and interventional radiology services and interventional radiology. There was also a department of nuclear medicine. Haematology and biochemistry services were provided by the onsite pathology laboratory for both in-patients and out-patients.

We visited the hospital on the 23,24,25 of February 2016. We spoke with the senior sister and the matron for the outpatient department (OPD) and the clinical specialist for anti-coagulation services. We also spoke with six consultants, one research nurse, two podiatrists, two qualified nurses and two health care assistants. In radiology we met with the team lead for radiology, radiation protection supervisor, the clinical tutor and the team lead for nuclear medicine and also the radiology manager. We also spoke with a student radiographer and a student podiatrist, a receptionist, two staff from pathology, the divisional director and five patients.

During the visit we spoke with staff and patients, we hosted a focus group for 19 allied health professionals and reviewed a range of patient records and trust policies and documents. We also reviewed information and data from a number of sources before and after the inspection.

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatient and radiology services at North Manchester as good overall. This was because

- Mandatory training levels were good and the environment was visibly clean and tidy. Equipment was checked regularly and there was evidence to support this. Staff knew how to report incidents and the learning from these incidents was followed up through regular staff meetings.
- Staff were using national guidelines which were being reviewed for compliance by the trust. There were good opportunities for staff development and evidence of effective multi-disciplinary team working. Leadership was good at an operational level in both OPD and radiology and information was shared at all levels in the division.
- Radiology services were safe with good incident reporting, there was learning from incidents that was fed back to staff.
- Pathology services were efficient with patient blood test results being available during clinics. The service was provided a 24 hour, seven day per week service.

However

- The did not attend for appointment (DNA) rates in OPD were higher than the England average and the trust did not have anything in place to address this. DNA rates were also high in the radiology department.
- The trust did not have any mechanism to measure the length of time that patients waited to see a clinician.
- There were issues around the storage of medicines in OPD clinics but the trust were working to change this with pharmacy colleagues.

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Are outpatient and diagnostic imaging services safe?

Good

We rated the outpatients and diagnostic services at North Manchester General hospital as good in the safe domain. This was because

- Staff knew how to report incidents and feedback to staff at meetings was good.
- There had been a number of serious incidents at the trust which had been investigated and lessons were learned. The outpatient areas were visibly clean and tidy with plentiful personal protective equipment available for staff; hand hygiene and environmental audits were completed.
- Mandatory training levels were good and the trust had a system to update managers on a weekly basis about the status of staff mandatory training.
- Resuscitation trolleys were checked daily and this was recorded and audited.
- In the radiology department appropriate processes were in place to ensure that radiological requirements for the department were met.
- Nurse staffing was adequate though there were vacancies and a recruitment day was planned There were vacancies in radiology and radiography and recruitment was underway.

However

- There were issues around the storage of medicines in OPD clinics but the trust were working to change this with pharmacy colleagues.

Incidents

- There had been no never events in the OPD and diagnostics departments at the hospital. Never events are serious largely preventable patient safety incidents that should not have occurred if the available preventative measures had been implemented.
- There were 25 incidents reported at the hospital from November 2014 to December 2015, these incidents were risk assessed as no harm incidents or low harm

incidents. Staff knew how to report incidents and were encouraged to do so on the trust electronic system. Staff meetings were used to feed back to staff about incidents.

- We heard staff apologising to patients if clinics were running late.
- In paediatric outpatients from December 2014 to December 2015, 16 incidents were reported. 93.7% of these incidents were identified as no harm or low harm. These incidents involved IT systems failures, booking and scheduling problems and documentation issues. The division's governance report highlighted that there were eight open incidents that had not been investigated. We escalated this issue to the paediatric matron at the time of our inspection and she took immediate action.
- There was separate incident reporting for radiology services. We looked at an example of a root cause analysis from an incident which showed lessons learned and changes in practice. Staff told us that the trust were sometimes slow to respond to incidents. Lessons learned from incidents was discussed at the monthly team meetings.
- The trust was undertaking a piece of work to reduce the number of incidents as a result of missed diagnoses of cancer across the trust. There was a five year look back exercise and a total of 159 cases had been reviewed. Of these, 40 cases were identified as definitely preventable and in 13 cases there was strong evidence of preventability. There was an improvement plan that was overseen by the diagnostics improvement group and this was submitted to the quality and performance committee of the board. The learning from the review identified a number of key areas different parts of the patient pathway. There was a trust action plan which included a number of areas including patient engagement, reviews of processes and patient pathways and revised policies and procedures. A piece of work was underway called your request/your responsibility which was training to advise staff on the correct procedures for referring and reviewing radiological testing. The improvement plan was submitted to the quality and improvement committee on the 23 February 2016.
- Letters were sent to all those affected by the issues, with an apology. There was information to raise awareness for patients about this matter in the radiology department but we didn't see any in the OPD.
- In the three months following the inspection, the trust were due to implement an additional module to the CRIS (clinical research information system) to enable the results for patients with critical findings to be seen more quickly by referrers to radiology services, an audit trail of messages would be sent and there would be acknowledgment of receipts of reports for the provider as part of the action plan for the missed diagnoses of cancer.
- There had been specific training sessions for radiology staff about the duty of candour at governance and audit days.
- Incidents about radiation were investigated by a neighbouring specialist cancer trust that would ensure patients had not received too much radiation. Staff who administered radiation had a 1:1 with the radiation protection officer and wrote a reflective piece about the incident. We saw an example of this.

Cleanliness, infection control and hygiene

- All areas we visited in the OPD were visibly clean and tidy. Although the estate was old in some of the clinics that we visited, these areas were also visibly clean and tidy. Curtains were disposable and the ones we checked were dated and noted to be in date. There were hand gel stations in the OPD which were well used and there were posters about infection control. PPE was available in all the OPD clinics that we visited.
- Hand hygiene audits were completed in the OPD every two months. The target was 90% though 100% was usually achieved.There were environmental audits and in all the clinical OPD areas the score was above the target of 85% for the period April 2014 to November 2015. There were also trolley mattress hygiene audits every three months.
- In the patient led assessment for cleanliness the department scored above 98% in all OPD areas inspected; the national average was 95.6%.
- In the infectious disease clinic there was a dedicated phlebotomy room for taking blood that was not used by any other clinics. The clinic had a separate entrance which led directly from outside the hospital into the clinic.
- There were audits in radiology for hand washing, room cleanliness and equipment cleanliness, which were at 100%. All areas were visibly clean and tidy

- Personal protective equipment (PPE) was plentiful and available in the radiology and nuclear medicine areas that we visited.

Environment and equipment

- The main OPD at the hospital was in a newer part of the building, however, some of the clinics were in different parts of the hospital and some were in separate buildings in the older part of the hospital. This included the diabetes centre and the breast clinic. The diabetic clinic was in a one storey building with plenty of clinical space. The breast clinic was part of the older estate and was light with good clinical areas and a small waiting room. The specialist breast care team were located in the upper floor of the building.
- There was a well-organised outpatients (WOOP) group which did site walk-arounds and looked at issues with the environment and the estate.
- The radiation protection supervisor worked to ensure that the radiological protection requirements for the department were met. Records that we inspected were ordered and concise and dose audits were undertaken to ensure that staff were not exposed to unsafe levels of radiation. There was a medical exposure group and a radiation support group to support this.
- There were appropriate warning signs on the doors in the radiology department.
- The department of nuclear medicine had “hot waiting” rooms for patients who had received a dose of radiation before they went for their test.The department had recently been inspected by the environmental agency; this was in line with the regulations for storage of radioactive substances. It had not been inspected by the police who check the storage of radioactive substances.
- When radioactive substances were delivered to the hospital, they were passed through a hatch in the outside wall of the laboratory. This meant that radioactive substances were not transported through the hospital. They were then stored in an appropriate locked and padlocked cupboard. Staff monitored the disposal of radioactive substances.

Medicines

- Medicines in the OPD sites were stored in the matron’s office in locked cupboards. Trays of medicines required for each clinic were put into trays for the use of the doctors or specialist nurses. These trays could be left unattended if the doctor left the clinic and if there was no nurse present though we did not see this during the visit. This was the highest risk on the departmental risk register and the trust was working with pharmacy colleagues to provide locked cupboards in each clinic.
- There were no controlled drugs used in OPD.

Records

- The trust used an electronic paper light system. There was an electronic outpatient clinical history sheet which ensured legibility, availability of records at all locations and the removal of risks around paper transportation and loss of records. The trust were also replacing the current elective admission proforma and using an intranet based referral that would allow the information to be saved into the electronic clinical record.
- Consultants reported they liked the system although they felt it could sometimes be slow and they could use their electronic hand held devices if the system was down. This allowed them access to the appropriate records. They also said that day cases could be a problem if the information was not scanned onto the system though they would have the referral letter.
- Data supplied by the trust showed 99.81% of patients were seen in the OPD with their medical records. If the notes were unavailable the paper notes were retrieved in advance of clinic and where these were absent this was escalated to the team leader. If the records remained unavailable a temporary set of notes was created and included relevant documents held in electronic format such as referral letters and diagnostic results and trust systems.

Safeguarding

- The OPD staff were aware of safeguarding of adults and children. Trained staff received training to level three, untrained staff and reception staff were trained to level two in the safe-guarding of children. Staff knew how to report safe-guarding incidents and how to refer urgent issues to the safe-guarding team.
- There had been a master class for staff on female genital mutilation.
- Prevent training was part of level two and level three safeguarding training, this was to prevent young people to be drawn into terrorism.
- The patient administration system (PAS) identified any safeguarding alerts.

Outpatients and diagnostic imaging

- All the band six and above staff in radiography were trained to level three in the safeguarding of children and adults and all staff including the medical staff were 100% compliant with their safe-guarding training.

Mandatory training

- Mandatory training levels for OPD staff across the trust were 90% but at NMGH they were 100%. The trust produced a weekly chart which informed managers of the status of the mandatory training of all staff. This enabled managers to allocate training time for staff dependant on any short term sickness or absence. The online training required a short test for completion and staff told us they felt that the training was good.
- All the staff in OPD were trained in basic life support skills.
- In paediatric outpatients at NMGH 100% of nursing staff were up to date with their essential job related training, 75% of additional clinical service staff were up to date with their essential job related training. For clinical service staff these figures fell below the trust's target of 94%. We escalated this to the trust.
- No nurses in paediatric OPD had advanced paediatric life-support training (APLS). This issue was escalated to the trust for immediate action.
- In radiology, mandatory training for staff was booked by the team lead; there was 97% compliance for mandatory training and in nuclear medicine there was 100% compliance with mandatory training.

Assessing and responding to patient risk

- There were resuscitation trolleys in OPD and diagnostics for adults and children. We saw that these were checked daily and that this was recorded.
- There were resuscitation trolleys in the nuclear medicine department for adults and children that were checked weekly.
- The last menstrual period sheet was completed for all patients of child bearing age in the radiology department. If there was any doubt a pregnancy test was undertaken.
- There were doctors co-located near to the cardiac stress laboratory in nuclear medicine in case of an emergency.
- There was an audit of the the world health organisation checklist for interventional radiology, the department was 96% compliant following the observation of 54 procedures.

Nursing staffing

- The allocation of nurse staffing was decided each morning dependent on short term sickness and absence. There was always one trained member of staff for each of the seven OPD areas. Senior staff said that nurse staffing could sometimes be a problem and there were currently a number of staff with long term sickness; however there was an escalation policy for the staffing of the department. Clinics were never cancelled due to nurse staffing.
- The consultants said that the OPD clinics were well staffed though it was sometimes difficult to staff evening and weekend clinics.
- Senior nurse manager said that it was difficult to get staff to do additional evening clinics and they usually covered the clinics themselves.
- There was a bank of staff for OPD and if agency staff were used they had experience of working in the department ensuring continuity. Staff were offered additional hours and overtime.
- We were told about a recruitment day for nursing staff in March. This was a one stop shop for recruitment with interviews on the day with support from human resources and occupational health. Some of the bank staff said that they were considering applying for permanent posts.
- A member of staff was rostered to remain in clinic until all patients had left. Staff received time in lieu for this.

Radiology and diagnostics

- There were 3.8 wte band 5 staffing vacancies in radiography, it was hoped that these would be filled in summer when students graduated. There was an additional band 4 staff to support the radiographers.
- There were rotas for the radiology staff; the band five staff worked on a 19 week rolling rota and the band six staff worked on a five week rolling rota. There were dedicated night staff and no on call rota. The rota had been brought in following consultation with staff who told us that there was a good work life balance and that they were aware of their work patterns allowing them to plan ahead.
- There were two floating weeks on the rota which allowed managers to cover sickness and absence, annual leave and training. Staff also worked weekends on the rota.

Outpatients and diagnostic imaging

- There were three dedicated radiographers for children.
- The trust had developed the role of the assistant practitioner in radiography across the hospital sites. This meant that there was skill mix in the departments.
- There were six staff including one part time staff in the nuclear medicine department.

Pathology

- The laboratory provided essential haematology and biochemistry services for both in-patients and out-patients at the hospital 24 hours a day seven days a week. Staffing was on a rotation between the sites ensuring that sickness and annual leave was covered.

Medical staffing

- Consultants reported no gaps at consultant level and clinics were consultant led. Consultants shared a secretary.
- Consultant radiology cover was provided on site Monday to Friday 9am to 5pm. Radiology on call services were provided weekday evenings 5pm to 9pm on a trust wide rota supported by the trust consultants and between 9pm to 9am general on call services were provided by an on call contractor. On call services at weekend between 9am to 9pm were provided by a consultant and a speciality trainee. Interventional radiology was provided out of hours on a trust wide rota between 5pm to 9am during weekdays and 9am to 9am on Saturday and Sunday.
- There were vacancies for radiologists across the trust. This was noted on the risk register. Interviews were planned and the trust had three applicants for two posts. Speciality trainees were encouraged to apply for posts in the department.

Major incident awareness and training

- There was a major incident policy with detail about the suspension of OPD clinics in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate the outpatient and radiology service at North Manchester General Hospital.

- The trust were reviewing National Institute of Health and Social Care Excellence (NICE) guidelines and other guidelines as part of a review process.
- Staff development was encouraged and there were opportunities for further education. Appraisal rates were 100% for staff in outpatients department (OPD) and radiology and there was good documentation to support this. The diabetes service was using shared care guidelines for positive patient outcomes. A nurse in the diabetes service was involved in research and had won awards for her work
- There were good relationships between doctors and nurses in the OPD and there was evidence of multidisciplinary working and nurse led clinics.
- In radiology there were a number of processes to ensure consistency of reporting and discrepancy meetings to improve patient safety and outcomes. Pathology and radiology results were available to staff through an electronic system.
- Some radiology and pathology services and were available seven days a week 24 hours a day.

Evidence-based care and treatment

- Staff were aware of NICE guidance and there was evidence of reviews and audits of guidance and guidelines in the minutes of meetings.
- The trust action plan for the misdiagnosis of cancer included development of a trust wide policy incorporating NICE guidelines and national patient safety agency 16 guidelines- the early identification of failure to act on radiological imaging reports. New standard operating procedures were also in development.
- There was a research nurse for diabetes and the research team had won awards for their research work, the trust was one of the largest recruiter of patients to clinical trials in the North West.
- The diabetes service was using NICE guidance and shared care guidelines for practitioners involved in the care of people with diabetes.
- The trust was using new NICE guidance on new oral anticoagulant drugs that do not require regular blood tests. They were working with commissioners to support this.
- The audiology teams for adult and paediatric audiology were participating in the improving quality for physiological services accreditation scheme.

- The radiology department held discrepancy meetings to facilitate learning from radiology discrepancies and errors and subsequently improve patient safety.

Pain relief

- Patients attending clinics would bring their own medication that was reviewed by the medical staff as appropriate.
- Analgesia and topical anaesthetics were available to children who required them in the outpatients department.

Patient outcomes

- The follow up to new rates for clinic attendances were higher than the England average. New appointments were 28% compared to 60% for follow up appointments. This meant patients were not discharged in a timely manner and the trust was in the bottom 50% of trusts in England for new to follow up rates. The figures for referral to treatment time and follow up have been provided by the Trust at the time of the inspection; however we have subsequently learnt these may be unreliable and are therefore not assured that performance is at this level. We are now working with Trust to validate this information and follow up any actions arising.
- Follow up rates did not include patients visiting the anti-coagulant clinics as they may have needed to attend for life.
- All staff in the trust were involved in "raising the bar on quality" which had ten key actions to make the trust and its services the best for staff and patients. These included improving the environment, making sure services were clean and safe, adherence to clinical standards and a focus on care and compassion
- There was an audit schedule for the OPD and for radiology. In OPD this included trolley mattress audits, an environmental audit, hand hygiene and hand washing audits, hospital acquired infections and medicines check. The environmental score in the department was always above the target score in the period April 2014 to November 2015 and hand hygiene audits always scored above 90% which was the target.
- In radiology there were was a comprehensive audit schedule that linked to compliance to NICE guidance and Royal College of Pysicians guidance and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- Physiotherapists and occupational therapists worked at the pre-assessment clinic in orthopaedics to ensure that patients met their therapy outcomes and were supported on discharge from the hospital. This involved a care plan and any equipment needed for their rehabilitation.
- There was a nurse led discharge clinic in orthopaedics to speed up the discharge process for the less complex patients
- In pathology, the trust was meeting the turnaround times for urgent and direct access blood tests.

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Competent staff

- The trust were supportive of further education and some of the nurses we spoke with had their degrees funded and were given time to attend university.
- Staff in the diabetes clinic were encouraged to undertake the Warwick course. This provided the practical knowledge and skills necessary to deliver an effective service for people with diabetes.
- The staff from the diabetes centre were training ward staff to manage foot ulceration so that these patients would not require treatment from the diabetes podiatry team when they were in-patients
- Appraisal rates in the OPD were 100% and were used as an opportunity to discuss staff development and opportunities for learning and development.
- In paediatric outpatients 40% of staff were up to date with their appraisals. The trust target was 90%. We escalated this issue to the service at the time of our inspection.
- Appraisal rates in the radiology department were 100%. There was good documentation and the manager spent at least one hour with staff. Appraisals fitted with the trust values and objectives were agreed to develop a personal development plan with links to training.
- Radiology and radiography staff peer reviewed and audited reports of other practitioners on a three monthly basis to ensure consistency in reporting.
- There were monthly continuing professional development (CPD) sessions for the reporting radiographers and there was in house training for radiography staff where possible from the radiologists and senior staff in the department.

Outpatients and diagnostic imaging

- There were clinical tutors in the radiology department for radiography students. The department worked closely with local universities in student training and this helped with staff recruitment.
- An e-learning package had been produced by the department for all referrers to radiology services; this was described as practical and informative by staff
- The department held informal meetings at lunch times to review interesting cases, they were aimed at radiologists, radiographers and staff who were referrers to radiology services

Multidisciplinary working

- There were good relationships between the doctors and outpatient staff. There were also specialist nurses who had their own clinics.
- There were two physicians from a local specialist cancer trust who attended the breast clinic to support the service.
- There was effective multi-disciplinary working in the diabetes service. Consultants, vascular surgeons, specialist nurses, podiatrists and orthotists worked together to provide a seamless service for people with diabetes. There were shared care guidelines for staff.
- The community podiatry team worked closely with the team in the hospital ensuring that patients were seen quickly and the trust were developing a community vascular team.
- Occupational therapists and physiotherapists worked together to support the orthopaedic clinics. There was a pre-operative clinic where the patient's equipment needs were assessed before surgery. This supported a quick discharge.
- The anti-coagulant staff worked effectively with the consultant haematologists. Staff described good two way feedback with the doctors that could prevent a delayed discharge
- There was close working between the department of nuclear medicine and the department of medical physics at a local specialist cancer trust.

Seven-day services

- There were some evening and Saturday OPD clinics being delivered, however these were to address waiting list initiatives.
- There was a seven day service for x-ray and computed tomography (CT) scanning for inpatients and outpatients at the hospital. Interventional radiology was available after 5pm and at weekends and this was a trust wide service.
- Pathology services were available seven days a week, 24 hours a day.

Access to information

- The trust used a web based application that allowed clinical staff to log into a number of different systems at any one time using a single sign in password to check the records of patients. This included requesting and reading radiology and pathology reports and electronic discharge summaries for patients. This gave an audit trail with an acknowledgement of the results and helped to prevent duplicate testing.
- Pathology results were available on line through the trust intranet system.
- The trust used an electronic system for medical records and consultants were issued with hand held electronic devices in case there was any failure in the system.
- There was a diabetes management information technology system which allowed the viewing and sharing of images in the podiatric service in acute and community settings. The images were photographed by a medical illustrator and could be viewed across the trust including the community.
- Staff in the anti-coagulant service had fed back about the ability to access information about patients while working in their homes. The trust had provided laptops to solve the problem.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date policy that covered consent, mental capacity and deprivation of liberty safeguards (DoLS), which was accessible to staff on the intranet and staff knew how to find it.
- Training for mental capacity act and DoLS was part of the level two and level three safeguarding training
- Staff from interventional radiology had undertaken a consent audit of patients. The audit showed that forms were legible and contained dates with a signature and the status of the practitioner. The correct forms were used and risk assessments were correct and consistent.

Outpatients and diagnostic imaging

- Staff in the radiology department were aware of the issues around the mental capacity of patients.
- 100% of paediatric nurses had completed their level two safeguarding training. However, only 62% of staff had completed their level three training. Whilst this was above the trust's target of 60%, the intercollegiate guidance on safeguarding outlines that 100% of staff working with children and young people should have completed this training. We escalated this issue to the trust at the time of our inspection for their immediate action.

Are outpatient and diagnostic imaging services caring?

Good

We rated the outpatient (OPD) and radiology service at North Manchester General Hospital as good in the caring domain.

- There was a trust wide approach to encourage staff to think about compassionate care in all their interactions with patients and patients we spoke with said that care was good in the department.
- The symptomatic breast clinic was supported by specialist nurses who had undertaken the advanced communication skill training and so could support patients in the clinic who were receiving bad news. In the outpatient department (OPD) there was always a trained member of staff working who would support patients receiving bad news.
- The radiology department had undertaken a patient experience survey in x-ray with positive results.
- The department scored lower than the national average in the patient led assessment of the care environment for privacy, dignity and well-being but had a higher score than the previous year.

Compassionate care

- The trust had implemented "raising the bar on quality" within the OPD, one of the actions included compassionate care. Staff were encouraged to think "compassion" in every action and interaction and to be approachable and respectful.
- Chaperones were availalble to support patients in clinics and during procedures if necessary, there was a chapereone policy on the trust intranet.
- Patients we spoke with said that the staff and care was good and one patient said she had received better treatment than she had at another local hospital.
- The specialist nurses knew their patients well and called them by their names into clinic.
- In the diabetic clinic consultants, nurses and allied health professionals knew their patients well as many of them had been attending the clinic for many years. They were friendly and respectful with patients. patients we spoke with said it was a good service.
- Staff interactions with patients were friendly but respectful. One patient we spoke with attended the hospital every two weeks and was complimentary about the specialist nurse who she saw.
- In the patient-led assessment of the care environment (PLACE) the OPD had scored 86% for privacy, dignity and well-being, the national average was 90.3%. this was an improvement on the score for the previous year.
- A member of staff was rostered to wait in the clinic until the last patient had gone home. These patients were usually older patients using the patient transport services. Staff ensured that they had received refreshments while they were waiting.
- A charity had been set up by a member of staff who had previously worked at the clinic to support patients attending the breast clinic. Funds were used to provide complementary therapies for patients undergoing treatment.
- The radiology department had undertaken a trust patient experience survey in x-ray. Out of a survey of 216 patients, results showed that 69% of people had an excellent experience and 29% had a good experience.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had received good information about their care and treatment and had been involved in decisions about their care.
- We saw staff helping patients and their carers in the clinics and in the radiology department including patients who had dementia or were confused.

Outpatients and diagnostic imaging

- The consultant we spoke with at the breast clinic delivered the results of the patients diagnosis at the end of the clinic. He was supportive and empathetic towards the patients
- At the symptomatic breast clinic we saw patients and their relatives supported by staff while they waited for their results at the end of the day. Refreshments were provided to patients and their carers while they waited for their results.
- The breast clinic had started a survey of patients to understand how they wanted to receive their results, the majority said that they would prefer to receive them on the same day.

Emotional support

- All out-patient clinics had at least one member of qualified staff who would break bad news and support patients if necessary.
- The breast care specialist nurses had done the advanced communication skills training to break bad news to patients in the symptomatic breast clinic.
- Staff in the clinic were supportive of each other if they were involved in difficult emotional situations.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the outpatient and diagnostic service at North Manchester General Hospital as good in the responsive domain. This was because

- There were a number of one stop clinics and nurse led clinics including a symptomatic breast clinic where women would receive a diagnosis, following a range of interventions, within the day. There were also rapid access outpatient clinics.
- There was a good podiatry service for patients with diabetes who could be seen in any clinic across the trust if necessary.
- Blood tests results from pathology were reported to clinics while the patients were still in clinic.
- There was no reporting backlog for any of the modalities for radiology.
- The patient tracking list group was chaired by a clinician and addressed individual patient issues along the cancer pathways.

However

- The trust had no mechanism to measure the number of patients waiting more than 30 minutes to see a clinician.
- Both the outpatient department (OPD) and the radiology department had high levels of patients who did not attend and there were no plans in place to address this.
- The phlebotomy service was being reviewed as it did not meet the needs of the service. The inpatient service was reduced if there were heavy demands on the outpatient service.

Service planning and delivery to meet the needs of local people

- There were six areas for out-patients in the hospital and a diabetes centre and breast clinic that were located in separate buildings. The diabetes centre was well –equipped with clinical rooms for doctors and nurses and treatment rooms for podiatrists and orthotists, the research nurse for diabetes was based in the building. The breast clinic was in an older part of the hospital with a waiting area and clinical rooms, the specialist breast care nurses were based in the upstairs of the building. There was a café in the main OPD at the hospital and refreshments were available in the diabetes centre
- There were 190 out-patient clinics every week at the hospital. Consultants said that the choose and book system for patients booking appointments worked well. The highest number of appointments were in the anti-coagulant clinics, followed by trauma and orthopaedics.
- There was a pre-operative clinic in orthopaedics where patients had blood samples and swabs taken and were assessed for their equipment needs by the physiotherapist and the occupational therapist to support discharge. This ensured that patients did not have to wait for equipment following surgery. Patients were encouraged to look round the ward and to meet staff and other patients.

Outpatients and diagnostic imaging

- The orthopaedic clinic had its own dedicated x-ray service ensuring that patients were seen in a timely way and doctors would receive the results of the x-rays while the patients were still in clinic and preventing unnecessary visits to the department.
- There was a nurse led clinic for orthopaedics where patients were reviewed two weeks following surgery.
- There was a one stop symptomatic breast clinic that could give women a diagnosis within the day. Biopsies were sent to the pathology service at Oldham Hospital and if the women chose to wait they were seen at 5pm. Those who didn't wish to wait received an appointment to see the consultant; however 99% waited to be seen on the same day. The clinic was in the process of conducting a survey about the processes in the breast clinic and how women were informed of their diagnosis. Although the survey was unfinished the vast majority of patients said they wanted their results on the same day. Patients and carers attending the clinic were provided with lunch and refreshments by the trust.
- Rapid access clinics included upper and lower gastro-intestinal, ear, nose and throat (ENT), oral, lung, clinical haematology, gynaecology clinic and transient ischaemic attack (TIA) clinic.
- A haematology consultant said that the links to the main pathology laboratory at Oldham were excellent and that some test results were reported while patients were still in clinic.
- Patients waiting for phlebotomy services waited a maximum of one hour. The service was for OPD, GP access and the wards.
- Podiatry services for people with diabetes were available every day between Monday and Friday at least one of the four hospital sites across the trust.
- There were 7500 patients attending the anti-coagulant service in NMGH and Rochdale. These clinics were for new or unstable patients, patients who required an interruption in their treatment and those who needed transport to the hospital. Other patients were seen at the community clinic of their choice.
- The trust were working with commissioners to roll out the new anti-coagulant drugs what do not require regular blood tests, which meant that patients would not have to attend the hospital as frequently.
- There was a did not attend policy for non attendance at the OPD with exceptions for the two week wait cancer patients, anticoagulation patients, paediatrics, and patients with infectious diseases.
- The department used patient group directions to supply prescription only medicines to certain groups of patients without prescriptions following appropriate training. This allowed timely prescribing of medicines for patients.
- The paediatric OPD had play specialists available Monday-Friday from 9am – 5pm.

Radiology and nuclear medicine.

- The radiologists had been involved in the development of one stop clinics for the gastrology clinic, the haematuria clinic, the lung clinic and the symptomatic breast clinic ensuring that patients attending these clinics received their radiology reports in a timely manner allowing the consultants to give a diagnosis on the day if possible. The specialist sonographers were also working with the gynaecological out-patient clinics to improve diagnosis and reduce patient appointments.
- There were dedicated CT and MR staff in radiology ensuring that patients were seen in a timely manner.
- In the radiology and diagnostic department there was a separate waiting room for children that was nicely decorated and welcoming. It had been decorated by the staff. There were dedicated rooms for x rays and ultrasound for children with toys and other distraction techniques**.** There was a separate children's waiting room, toilets and baby changing area in the nuclear medicine department. There was a dedicated entrance for patients to radiology from the A and E department so that patients could be moved between the departments in a timely manner.
- In the department of nuclear medicine there were two single-photon emission computed tomography (SPECT) cameras that produced three dimensional images; there was space for a third camera. The department also did cardiac stress testing and had a separate cardiac stress room and a recovery room.

Pathology

- Blood results were available to staff before the patients left the clinic. Urgent abnormal results were phoned through to clinics.

Access and flow

- OPD clinics, including paediatrics, started at 8.30am and finished at 5pm Monday to Friday. Consultants could

adjust the length of appointments to accommodate new patients and follow up appointments. If clinics were cancelled it was due to lack of consultant cover, clinics were never cancelled due to lack of nursing cover.

- Clinics sometimes ran late, consultants said that clinics could run up to two hours late. Patients were informed of the delay when they booked into clinic but this information was not always written up on the whiteboards.
- The referral to treatment waiting times for January 2016 were 96.1% of patients were seen within 18 weeks with half of the patients seen in six weeks. In November and December 2015 this figure was 98%. The operational standard was 92%.
- The above figures have been provided by the Trust at the time of the inspection; however we have subsequently learnt these may be unreliable and are therefore not assured that performance is at this level. We are now working with Trust to validate this information and follow up any actions arising.
- The trust had monthly referral to treatment times (RTT) meetings and action plans were in place to improve the RTT times in a number of specialities.
- The cancer waiting times for the trust were better than the England average. 96.5% of patients were seen within the two week waiting time for cancer compared to the England average of 94.8%. The 31day to 1st treatment target was 99.4% compared to the England average of 97.9% and the 62 day target for referral from G.P.to treatment was 88.8% compared to the England average of 83.5%.
- There was a booking centre for all appointments in the OPD, this was based at Rochdale. The staff worked in specialty/ pathway teams with a co-ordinator tracker to track referral to treatment times (RTT) for their speciality. The teams met weekly and the pathway co-ordinator fed back any problems to the clinical teams any problems with RTT. The process engaged with clinicians as trackers attended directorate meetings; the tracker would inform clinicians of the impact of actions that could arise due to the cancellation of clinics e.g. annual leave booked at short notice.
- If a clinic needed to be cancelled the consultant's secretary would complete a form and send it to the team. If this was short notice, staff would try to contact patients by phone or letters would be sent by taxi. Only directorate managers were able to cancel clinics according to the trust policy. Clinic cancellations were minimal and the booking staff said that they had been minimal during the junior doctors strike.
- The did not attend rate (DNA) for the hospital was 12%, the England average was seven per cent. The trust did not have a plan in place to address this.
- There were additional clinics to address waiting lists in the evenings and at weekends. These clinics were usually colo-rectal to meet the demand from the bowel screening programme.
- Delays in the OPD were often due to patient transport services. (PTS).Managers had regular meetings with the PTS service managers and staff sometimes had to stay late waiting for patients to be picked up. A member of staff was allocated this role on a daily basis ensuring that vulnerable patients were not left alone. The current holder of the PTS contract had not re-tendered for the contract.
- The phlebotomy service was under review as the current situation was unsustainable. The service was available for out-patients and GP access and for in-patients though if the service was short staffed the in-patient service was reduced and would sometimes run on alternate days. The medical staff was unhappy about the service. There was no weekend in-patient phlebotomy service. This was on the risk register.
- New appointments for the anti-coagulant clinic were sent out by first class post to ensure that patients received them in a timely manner.
- The trust had no mechanism to measure the number of patients waiting more than 30 minutes to see a clinician or the proportion of clinics starting late.

Radiology

- The hospital had two CT scanners operating Monday-Friday 9am to 5pm. All the scanners had a mixed schedule of inpatients and outpatients. The CT had an out of hours service 24 hours per day, seven days a week for emergencies. The magnetic resonance scanner (MR) operated Monday to Sunday 8am to 8pm. X ray services operated 24 hours a day seven days a week for in-patients and out-patients. There was non-obstetric ultrasound including vascular Monday-Friday 9am to 5pm for in-patients and out-patients and obstetric ultrasound was available from 8.30am to 5.30 pm from Monday to Friday. There was breast radiology Monday to Friday 8.30 am to 5.30

pm and interventional radiology Monday to Friday 9am to 5pm. There was a trust wide service for interventional radiology 5pm to 9am weekdays and 9am to 9am on Saturdays and Sundays. Nuclear medicine and neurophysiology operated Monday to Friday 9am to 5pm.

- Radiology appointments were arranged from the booking centre by the radiology booking team. There was a standardised booking procedure which gave patients the next available appointment at any site for a radiology test. This reduced the length of time that people needed to wait for an appointment.
- In January 2016, across the trust, the percentage of people waiting more than six weeks for diagnostic tests and procedures was 6.9%. There were 40 people waiting for an MRI scan and 38 for an ultrasound scan. There were 64 patients waiting for a colonoscopy, 22 for a sigmoidoscopy and 117 for a gastroscopy. This was an improvement on the numbers from the previous month. The trust was aware of the issues and had an action plan to reduce the numbers. This included training nurses to undertake some diagnostic procedures following training and a competency assessment.
- There was no backlog in the reporting of any of the modalities in radiology. This was monitored and the workload was distributed between the radiologists with additional onsite reporting. Some reporting was outsourced. This was part of the response to the missed cancer diagnoses. This had been recognised nationally as good practice.
- The radiology department had high levels of patients who did not attend (DNA) for appointments. There was a policy for patients who did not attend. The trust did not have a plan to reduce the DNA rate.
- The department monitored the average time from attendance to imaging and the number of appointments attended. This allowed different modalities to benchmark their waiting times against each other.
- There were reporting radiographers; this ensured that patients received their results in a timely way.
- There was a dedicated cannulation room which ensured good access and flow into the CT suite.

Meeting people's individual needs

- The patient advice and liaison service (PALS) was situated at the front door of the hospital close to the OPD and was very accessible for patients to make complaints or raise issues about services.
- There were 82 languages spoken across the geographical area and there were 107 bank interpreters. Translators were available and we saw evidence that they were used in clinics; they could be booked and would provide face to face translation but if staff were unaware that a patient needed a translator telephone translation was used. Telephone translation was available 24 hours per day. Leaflets were available in a variety of languages.
- There was an anti-coagulant service for housebound patients and patients attended clinics from the local prison.
- The staff who worked at the breast clinic was a dedicated team ensuring continuity of care for the women attending the clinic.
- The diabetes clinic provided a session for children and young people between 17-25 yrs. every month.
- There was a podiatry clinic available across the trust every week day for patients with diabetes. The podiatry staff, including the community staff, had the mobile phone number of the consultant so that they could ring for advice if necessary.
- There was a venesection team for those patients with difficult access to veins, particularly intra-venous substance users. The medical staff said that this was a useful service.
- There were cubicles for people with a disability or people who used a wheelchair in the radiology department.
- The patient tracking list was clinically led; it was chaired by the clinical director. The tracking list measured progress on the 31/62 day cancer pathway. It was used to solve individual patient issues on the pathway e.g. delayed tests or surgery. The meetings were attended by clinicians and consultants and were held at all four sites. The attendance of consultants and clinicians was good practice.
- There was good communication with people with a learning disability and radiology staff who described how they would approach a patient and their carer.
- The paediatric radiologist and the paediatric radiologist for nuclear medicine were co-located and worked closely together to ensure that reporting was seamless.

Outpatients and diagnostic imaging

Learning from complaints and concerns

- Complaints were an agenda item on the monthly directorate meetings which were fed down to the operational managers for feedback to staff. In the first six months of the year, April to September 2015 there were 20 complaints; these were mainly about staff or procedures in the OPD.
- There had been a year on year reduction in people dissatisfied with complaints in the trust.
- Most complaints about the department were informal and were dealt with by the nurse managers in the departments. Feedback to staff was at the weekly meetings.

Are outpatient and diagnostic imaging services well-led?

Good

We rated the out-patients and diagnostic imaging services at North Manchester General hospital as good in the well led domain. this was because

- The trust were involved in strategic change across the health economy in both health and social care, staff were aware of impending change. Staff, patients and the public had been involved in the development of the vision and values for the trust.
- Doctors and staff said that the trust board was visible and that the culture was open, Management was effective at local level and staff thought the new nurse manager in the OPD had made a difference in a short time.
- There was an open culture amongst the staff in the OPD and they were happy to raise concerns.
- There was a new manager in the radiology service who was beginning to make changes in the service.

However

- There was a lack of management structure and reporting accountability in radiology services.
- Sickness levels in the OPD were above the directorate target of five percent but mangers were working with human resource colleagues to address this
- Allied health professionals had lost their senior manager and felt that their contribution to service design was overlooked and that they had no voice in the organisation.

Vision and strategy for this service

- There were strategic changes that the trust was involved in across Greater Manchester in both health and social care. The delivery of care of the hospitals in the trust was likely to change as strategic changes were implemented.
- External management consultants had been involved in an option appraisal exercise which included OPD, radiology and pathology services, these services would support any new configuration of the trust.
- There was a vision, values and a strategy for the trust that had been developed with staff, stakeholders and the general public. Posters and pop ups were evident all around the OPD and radiology departments. Staff said that they felt involved in the process.
- Staff were aware of impending change and were accustomed to it. There had been significant change in the trust over the last few years.

Governance, risk management and quality measurement

- OPD, radiology and pathology were part of the support services division. There were quality and performance meetings that were held monthly which were chaired by the director of the division. The meetings focused on targets for all services included in the division and agenda items included patient safety, patient experience, clinical outcomes, performance monitoring, the assurance framework and risks and the risk register. Actions were put in place if services were not achieving targets.
- Quality and performance for paediatric OPD were monitored through the paediatric dashboard. This covered data such as sickness rates, new complaints, RTT (referral to treatment times) and additional information such as appointment cancellations and DNA (Did Not Attend) rates.
- There were monthly department managers meeting about strategic and operational issues and this fed

down to the weekly meetings which were held with OPD staff. There were staff meetings and staff received feedback about incidents and complaints and trust issues including the team brief.
- Consultants met monthly and also held regular audit meetings with the interim medical director.
- There was a trust cancer performance meeting that had made 35 recommendations about services four or five months ago, these recommendations had been resolved and the team members were pleased with the timely resolution of the recommendations.
- There was a radiation safety group who met every three months, agenda items included equipment, radiation incidents, dose audits and dosimetry for radiologists and radiographers. One of the agenda items included an action to update risk assessments. They produced an annual report
- There was a departmental risk register for OPD and radiology services. The registers contained actions and target dates for the management/resolution of the risk.

Leadership of service

- Consultants we spoke with said that the trust board were visible as was the interim medical director
- Four consultants that we spoke with said that the OPD ran well at an operational level and that they had no concerns about the service.
- Leadership in the OPD was effective at an operational level; the matron worked well with the senior staff nurses from all the sites.
- Some work has started within the trust and a roll out programme for partial booking of follow ups for new patients seen since the initial paper was collated has been started however the programme has not yet been completed for all specialties.
- The matron who managed the OPD service met monthly with the deputy chief nurse for her appraisals and one to one meetings which were described as effective meetings. The divisional director was non-clinical and the matron said that there were no other nurses at her level in the OPD and she sometimes felt isolated. The senior sister in OPD, who was new in post, said that she felt well supported by the matron.
- Nursing staff in the OPD said that although the senior sister hadn't been in post very long she had already made a difference to the department. Staff said that they were pleased about her appointment and some bank staff said that they would apply for permanent posts because of her appointment.
- The matron for OPD said that the recent reorganisation of the divisions had worked and been good for the OPD service.
- The senior nurses and the matron in OPD and anti-coagulation maintained their skills and competencies and would help out in clinic if necessary. One of the managers of the anti-coagulant service was the chair of a national clinical network.
- There was a new manager in radiology and leadership of the radiologists and radiographers was effective. The new service manager was beginning to make changes to the service, the radiographers were well organised and were providing a service that met the demands placed on it. Although not fully staffed radiologists were using their capacity to the best advantage to support the service.
- Allied health professionals (AHP's) reported that since the AHP manger had left the trust that they had not been replaced and the staff felt that they had lost their voice at senior level. Clinical managers were not invited to be part of the redesign of their own service and that services had been developed without taking into account the input of AHP's and then expected to provide a service out of existing capacity.

Culture within the service

- Staff said that the chief executive officer had provided a culture of openness and that management was visible. They said that they got to know what they needed to know and that the team talks had been inspirational. They also said the Monday message worked to disseminate information. Staff we spoke to said they liked the Monday message.
- Staff said that the culture in the OPD was open and they were happy to raise issues and concerns.
- The human resources service was contracted to an external provider. A manager we spoke with said the service was very helpful and supportive.
- There high levels of sickness in the OPD, they had consistently been at 6% which was above the 5% directorate target. There was a combination of long term sickness and short term sickness and managers were working with the human resources service to manage this. Sickness absence was reported at

divisional weekly meetings and there was a sickness absence management group to review, track and improve the management of long term sickness absence.
- The sickness levels in the anti-coagulant service were very low.
- The radiologists described good team working though the workload was continually increasing.
- There has been training for radiology / radiography staff on the duty of candour following the review of missed cancer diagnoses.

Public engagement

- The trust had worked with the public on the vision, values and strategy for the trust; they had used crowd sourcing as a way of obtaining ideas and information from a large group of people.
- The trust website provided some helpful information about the OPD and hospital services in general**.**
- Patients were involved in patient led assessments of the care environment (PLACE) visits.

Staff engagement

- In 2014, the 'chief executive's challenge' was introduced. Staff were asked to be involved in developing the trust vision and values. This challenge received 27,000 ideas from the workforce. Staff had also been asked to give their views on reducing staff sickness absence rates. The development of the trusts "healthy, happy, here" programme was the result of the 44,000 contributions. The third challenge had recently been completed and led to the development of the 10 "raising the bar on quality" actions.
- Staff awards were held annually, recognising team and individual staff patient care, dedication and innovation.
- There was a Monday message that went out from the chief executive of the trust to all staff. This was generally well received.
- Staff at the breast clinic had been mentioned in the Monday message and were proud of their service and their achievements.
- Staff received a monthly edition of 'Team Talk' which was a magazine produced by the executive team to inform staff of the latest news**.**
- There was a staff health and well- being plan and staff were offered ten weeks of free zumba classes.

Innovation, improvement and sustainability

- The radiology department had no backlog in reporting in any modalities, this had been recognised nationally.
- The diabetes research nurse had won a number of awards for clinical research and the trust were proud of their achievements at attracting funding particularly as they were not a university hospital. The trust was the second best recruiter to clinical trials in Greater Manchester.

Outstanding practice and areas for improvement

Outstanding practice

The introduction of PCR testing for clostridium-difficile ensured rapid results were available to medical teams to reduce the potential spread of infection within inpatient areas.

The paediatric unit had created specific packs to support parents whose children were having specific procedures for example a DVD and self-help pack had been created for children having spiker surgery. This included contact details for parents who had had a similar experience.

The neonatal unit had a range of leaflets that complemented their 'baby passport'. The leaflets were staged depending on the baby's development. Parents were prompted via the 'baby passport' and nursing staff to know which information leaflets were relevant to them at a particular point in time.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The hospital must take action to reduce the numbers of delayed and out of hours discharges from critical care.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The hospital should ensure that there is a supernumerary band 6/7 shift co-ordinator on duty 24/7.
- Ensure that the critical care risks on the risk register are regularly reviewed and updated with actions.
- Consider how it can embed training on Duty of Candour to all staff.
- Consider how it is going to embed the delirium strategy into the day to day care of patients receiving critical care.
- Consider how it is going to meet the intensive care society standards for the provision of pharmacy and allied health professional support to the critical care service.
- Ensure that the management of sharps complies with infection control and health and safety guidance.
- Ensure that In paediatric outpatients staff are up to date with their appraisals.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. - (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which as registered person must do to comply with that paragraph include - (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (g) the proper and safe management of medicines; (h) assessing the risk of, an preventing, detecting and controlling the spread of, infections, including those that are health care associated; (I) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18. - (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must - (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17. - (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15. - (1) All premises and equipment used by the service provider must be - (c) suitable for the purpose for which they are being used,

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. - (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which as registered person must do to comply with that paragraph include - (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks;

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18. - (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must - (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17. - (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs 14. - (1) The nutritional and hydration needs of service users must be met.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

13. - (1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...