Care Quality Commission

Tameside Hospital NHS Foundation Trust

Tameside 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	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Tameside General Hospital is part of Tameside Hospital NHS Foundation Trust and provides a full range of hospital services, including general and specialist medicine, general and specialist surgery and full Consultant led obstetric and paediatric hospital services for women, children and babies.

Tameside General Hospital is situated in Ashton–under-Lyne. The hospital services a population of approximately 250,000 residing in the surrounding area of Tameside in Greater Manchester, and the town of Glossop in Derbyshire. In total, the trust has 524 beds.

We carried out this inspection to see whether the hospital had made improvements since our last inspection in May 2014. Following our inspection in May 2014 we rated the hospital as 'Inadequate' overall. We judged the hospital to be 'Inadequate' for safe and responsive and 'Requires improvement' for effective and well led. CQC was specifically concerned about the critical care services, but also about Medical, Surgical and Outpatients services.

We visited the hospital as part of our announced inspection on 28-29 April 2015. We also carried out an out-of-hours unannounced visit on 14 May 2015. The inspection team inspected the following core services:

• Urgent and emergency services

• Medical care services (including older people's care)

• Surgery

• Critical care

• Outpatients and diagnostic services

In our 2014 inspection we rated urgent and emergency services as good; but since that visit the CQC A&E survey showed that the services had the worst response in the country. We visited this service during this inspection to understand the reason for this change and to provide an assurance on the current position.

Overall, we rated Tameside General Hospital as 'requires improvement'. We have judged the service as 'good' for caring and well led. We noted that there had been significant improvements in some areas since our last inspection, most notably in critical services and outpatient services. However, improvements were needed to ensure that services were safe, effective and responsive to people's needs.

Our key findings were as follows:

Access and Flow

- Access and flow in the emergency department was a continuous challenge. The trust had a mixed performance against the four hour target over the year. Performance declined over the winter period, and they had regularly not achieved the standard since December 2014.
- Between July 2013 to January 2015 there were 32 black breaches at the hospital. 'Black breach' refers to failure to hand over a patient from the ambulance within 60 minutes of arrival at the emergency department. In the majority of cases, no reason was given for the breach.
- The total time in the emergency department per patient was worse than the England average over the period January 2013 to September 2014,
- Patient flow through the hospital and discharge had improved but improvements were still needed. Due to continual bed pressures there were occasions when patients had been transferred from the Acute Medical Unit during the night and medical outliers were still common place. This meant that some patients were not placed in the area best suited to their needs. In such instances, the hospital had systems in place to ensure the timely review of these patients.

Summary of findings

- In critical care the number of patients that were admitted within four hours of referral ranged between 29.4% and 78.6% between April 2014 and March 2015. This meant the trust's target to admit 95% of patients within four hours of referral had not been achieved. During this period, a total of 46 patients had been discharged during out-of-hours. The hospital's target was for zero out-of-hours patient discharges. The service reconfiguration (due June 2015) aimed to improve capacity by separating the intensive care and high dependency into two separate units, with each unit having six allocated beds.
- There were improvements to the access for patients in the outpatient department since the last inspection. This included reduced waiting lists and the service was better than the England average in meeting the two week cancer wait targets and urgent GP referrals. However, there remained long waits for patients in some clinics.

Cleanliness and Infection control

- Patients were cared for in a visibly clean and hygienic environment.
- Staff followed the trust policy on infection control and adhered to the 'bare below the elbows' policy.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a suitable supply of hand wash sinks and hand gels available.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.
- Public Health England data showed 4.7% of patients acquired surgical site infections following fractured neck of femur (hip) surgery at the hospital between January 2014 and December 2014. This was worse than the national average of 1.3%.
- There was an action plan to improve surgical site infections. This included additional surveillance of the monitoring of patients temperature in theatre by the infection prevention surveillance nurse, additional training for theatres staff regarding the recording of patient temperature in theatre and recovery and the purchase of additional patient body warmer equipment for use during surgery.

Nurse staffing

- Care and treatment was delivered by committed and caring staff who worked hard to provide patients with good services.
- The expected and actual staffing levels were displayed on a notice board on each unit/ward and these were updated on a daily basis.
- Staffing levels were planned to ensure an appropriate skill mix to provide care and treatment for patients.
- However, nurse staffing levels, although improved, remained a challenge in some areas. This was particularly the case in medical care services and critical care. Staffing levels were maintained by staff regularly working overtime and with the use of bank or agency staff. Where possible, regular agency and bank staff were used which meant they were familiar with policies and procedures. Any new agency staff received an induction prior to working on the wards.
- The trust had implemented a number of initiatives to address shortages in nurse staffing including: monthly assessment centres, actively recruiting nursing staff from overseas and linking with local universities.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The proportion of middle career doctors and junior doctors within the trust was greater than the England average. The proportion of consultants was below the England average (35% compared with the England average of 40%). The proportion of registrars was also below the England average (20% compared with the England average of 37%).

Summary of findings

- Despite ongoing recruitment campaigns, the overall numbers of medical staff had only increased marginally in 12 months. Difficulties remained in recruiting medical staff particularly in urgent and emergency services, acute medicine and radiology.
- The emergency department was funded for 17 middle grade doctors. Eight doctors were currently in post with the remaining vacancies covered through agency locums.
- The number of medical staff in some clinical specialities had increased, such as respiratory medicine. Consultants told us this meant they could do more outpatients clinics because there were enough middle grade doctors to cover the wards, out of hours work and the outpatient clinics.
- There was one consultant haematologist in the hospital. This resulted in a shortfall in provision, particularly out of hours cover, which had been included on the risk register since September 2014. There were plans to develop a shared post with other hospitals in the area and in the meantime locums were used with a rotational on call system for consultant cover which included other hospitals. We were told this temporary arrangement was not ideal, but it had not resulted in any patient safety incidents.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum and agency doctors had worked at the hospital on extended contracts so they were familiar with the hospital's policies and procedures.
- The existing on-call consultant rota for critical care services included a combination of critical care specialist and surgical consultant anaesthetists. The on-call consultant cover was not always provided by a consultant in intensive care medicine. This meant a consultant in intensive care medicine was not available 24 hours a day, seven days a week, to attend a patient within 30 minutes as set out in the ICS standards. The hospital planned to address this by splitting the rota so on-call cover for the critical care services was provided by specialist consultants only but this was not yet in place.
- The hospital was looking at different ways to recruit medical staff for example, international recruitment and joint recruitment with other trusts.

Mortality rates

- In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce as part of the Keogh Mortality Review in July that year. After that review, the trust entered special measures because there were concerns about the care of emergency patients and those whose condition might deteriorate.
- Our intelligent monitoring report highlighted the trust as being either a risk or an elevated risk for the following mortality outliers and in-hospital mortality indicators: Summary Hospital-level Mortality Indicator, gastroenterological and hepatological conditions and procedures, infectious diseases, conditions associated with mental health, nephrological conditions, vascular conditions and procedures. On request, the trust had provided the Care Quality Commission's outliers panel with the relevant information requested and could evidence that a full investigation had taken place to understand the mortality data and identify areas for improvement.
- During our inspection, we found that patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at monthly mortality meetings, attended by multidisciplinary staff. The meetings identified the circumstances of the patient, the initial and follow-up care and treatment they had received and the circumstances of the death. We saw evidence of how learning from such situations was shared with teams.
- Since February 2014 a systematic review of all inpatient adult deaths had been completed. There was a Commissioning for Quality and Innovation (CQUIN) target for all eligible deceased case notes to be triaged by senior nurses and clinicians in the Quality and Governance Unit, and a mortality review to be completed within two weeks of the initial triage by a senior nurse/consultant/staff grade doctor. These cases were checked for coding accuracy with a senior coder. The clinical director for medicine told us the coding system was under scrutiny at the time of our inspection as the trust believed it was not coding all comorbidities for patients admitted.

Summary of findings

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and the speech and language therapy team.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.
- Data provided by the trust showed it had rated itself as 'amber' against the 10 key characteristics of good nutritional care (Nutrition Alliance) and as 'green' against use of the malnutrition universal screening tool (MUST).
- Wards operated a red tray system which identified patients who were assessed as being at nutritional risk and who needed support to eat and drink.
- However, the trust performed worse than the English average for the majority of indicators in the National Diabetes Inpatient Audit (NaDIA) September 2013. It was not clear what action the trust had taken to improve as a result of this audit. However, the trust acknowledged that it had improvements to make against key characteristics of good nutritional care including diabetes care.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that medical staffing is sufficient and appropriate to meet the needs of patients at all times including out of hours.
- Improve patient flow throughout the hospital to reduce the number of patients transferred at night and ensure timely access to the service best suited to meet the patient's needs, particularly in A&E and medical care services.
- Improve the completion levels of mandatory training and appraisals for nursing and medical staff.
- Ensure that medicines, particularly controlled drugs are stored, checked and disposed of in line with best practice in all areas but particularly in A&E and Outpatients.

Action the hospital SHOULD take to improve

In urgent and emergency care services:

- Ensure staff are trained in assessing patients using NEWS and MEWS and accurately record scores.
- Ensure all action plans in relation to CEM audits are specific and measurable.
- Ensure pain scores are routinely recorded for all patients and pain relief is prescribed and administered in a timely manner.
- Ensure all staff are aware of their responsibilities in relation to safeguarding and consent in relation to the mental capacity act and deprivation of liberties.

In medical care services:

- Take action to improve outcomes for patients particularly those with diabetes, heart failure and patients who have had a stroke.

In surgery:

- Improve surgical site infection rates for patients following orthopaedic surgery.
- Improve theatre efficiency to reduce delays in theatre session start times.
- Improve the timeliness of responses to patient complaints.
- Improve compliance against 18 week referral to treatment standards for ENT and trauma and orthopaedics for admitted patients.
- Improve the number of patients whose operations were cancelled and were not re-booked within the 28 days.

In critical care:

Summary of findings

- Improve the number of patients admitted to the critical care services within four hours.
- Reduce the number of out-of-hour patient discharges.
- Improve the timeliness of responses to patient complaints.

In outpatients and diagnostic imaging services:

- Continue to take action in improving waiting times in all clinics.
- Ensure there is a system in place to audit changes to practice and procedures in order to monitor their effectiveness.
- Ensure all staff are familiar with, suitably trained and competent to use resuscitation equipment.

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	Requires improvement 	In our 2014 inspection we rated urgent and emergency care services as good; but since that visit the CQC A&E survey showed the services as having the worst response in the country. We visited this service during this inspection to understand the reason for this change. It should also be noted that previously we were not confident that we were collecting sufficient evidence to rate effectiveness for urgent and emergency services. This has now changed and so during this inspection we also provided a rating for 'Effective'. As a result of this inspection we have rated the service as 'Requires Improvement'. During this inspection, we found that learning from incidents was discussed by senior staff at clinical governance meetings. Although staff told us they received feedback relating to incidents they had personally reported; themes and trends of incidents were not consistently discussed at team meetings. There was a clear governance structure to identify risk and performance management. However, whilst the right structures were in place they were not fully embedded at the time of inspection to ensure robust learning and improvement. During our previous inspection we found that pain assessment and pain scores were not routinely carried out and recorded. During this inspection we identified the same concerns in relation to the timely assessment and administration of pain relief. Local and national audits had also identified that pain assessment and control was not being managed appropriately. However, the action plans in place to address identified issues did not always include clear, measurable, specific actions and timescales. It was not clear how the successful implementation of these action plans was being monitored. As a result we were not assured that there were robust systems in place within the service to monitor and improve the quality and safety of services provided. In the paediatric and 'resuscitation' areas of the emergency department we noted multiple omissions in daily stock check records of controlled medicines. In two records, the national early

Summary of findings

warning scores (NEWS) had been underscored. This could result in patients not being monitored or reviewed appropriately. Again the monitoring and recording of observations was identified as an area for improvement during the previous inspection. A maternal early warning system (MEWS) had been introduced but not all staff were aware of the form or had received training in its use. When reviewing care records we found two cases where vulnerable patients should have been referred to the safeguarding team and were not.

The emergency department was failing to meet many of the national access targets. For example, time to treatment and total time within the emergency department. However, the department was working closely with the local clinical commissioning group, the council, ambulance service and community partners to address admission avoidance schemes, to improve flow through the department.

Evidence-based care was delivered in line with National Institute of Clinical Excellence (NICE) and Royal College guidelines. We observed that staff were friendly, caring and responsive to patient's needs. Patients and relatives were complimentary about the staff, comments included, "They've been brilliant, not had to ask for anything."

Medical care — **Requires improvement**

In 2014 we found the quality of patient safety was inadequate to protect people from avoidable harm. Our inspection in April 2015 found significant improvements. These included systems to manage and monitor safety that all staff contributed to and a culture of improved openness among staff to report mistakes and incidents. There were arrangements in place for the service to learn when things go wrong. Staffing levels had been reviewed and improved.

We found that although significant changes had been made to improve the effectiveness of services, further improvement was still required. Nursing and medical staff had the skills they needed to carry out their roles effectively and they worked well together including across different roles. However the service performed almost consistently worse than other trusts across a number of outcome indicators during 2014. This meant that outcomes for people were below expectations compared with similar services.

Summary of findings

Access and flow within medical care services remained an ongoing challenge. Local managers told us that patient flow through the hospital and discharge had improved but they were aware of improvements that still needed to be made. Due to bed pressures there were occasions when patients had been transferred from the MAU during the night and outliers were still common place. In such instances, the hospital had systems in place to ensure the timely review of these patients. However, we found there was no specific policy for transfers at night although ward managers told us they tried not to do so.

There were good systems, facilities and staffing skills in place to respond to the needs of patients living with dementia. People told us they were well cared for and staff were kind to them and staff responded compassionately when people needed support to meet their basic personal needs with dignity.

The executive team, including the chief nurse were visible and leading on a clear vision for change and improvement. The hospital was in the process of reviewing how services provided in the future would look and as a result this impacted on the ability of medical services to develop a long term strategy. However, local leaders were clear about the challenges and were able to identify significant developments which had contributed to improved patient care.

Surgery

Good

During our previous inspection in May 2014, we found the surgical services at this hospital required improvement. During that inspection, we found improvements were needed in the processes for patient safety, effectiveness of treatments, responsiveness of the services and leadership and governance.

During this inspection we found that patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in clean and suitably maintained premises. Care and treatment followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical

Summary of findings

performance measures. The staffing levels and skills mix was sufficient to meet patients' needs. Staff received mandatory training. However, the number of staff that had completed mandatory training was below the hospital's expected levels.
The majority of patients had a positive outcome following their care and treatment. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards. Patients spoke positively about their care and treatment and they were treated with dignity and compassion. The trust vision and values had been cascaded and staff understood them. The wards and theatres had clear and clearly visible leadership with clinical, nursing and business leads.
However, surgical services had failed to meet 18 week referral to treatment standards for ear, nose and throat (ENT) surgery and for trauma and orthopaedics during the past year. The plans to improve compliance included improved planning and theatre capacity and the use of external healthcare organisations to treat patients awaiting surgery. The rate of surgical site infections following fractured neck of femur (hip) surgery at the hospital was 4.7% between January 2014 and December 2014. This was worse than the national average of 1.3%. The action plan to improve surgical site infections included monitoring of patients temperature in theatre and additional training for theatres staff.
There were 550 operations cancelled between May 2014 and April 2015. The number of patients whose operations were cancelled and were not treated within 28 days was worse than the England average between October 2012 and September 2014. Theatre sessions were frequently delayed and started more than 15 minutes late due to patient management and surgeon or anaesthetist delays. The majority of complaints were not resolved and responded to within the agreed time frames.

Critical care

Good

During our previous inspection in May 2014, we rated the critical care services at this hospital as inadequate. During that inspection, we found

Summary of findings

improvements were needed in the processes for patient safety, effectiveness of treatments, responsiveness of the services and leadership and governance.

During this inspection we found the staffing levels and skills mix was sufficient to meet patients' needs. However, the on-call consultant cover was not always provided by a consultant in intensive care medicine. The service planned to address this by creating a separate on-call rota to provide cover specifically for the critical care services. The majority of staff had completed their mandatory training but the hospital's target of 95% compliance had not been fully achieved. Patient safety was monitored and incidents were investigated and shared with staff to assist learning and improve care. Patients received care in clean and suitably maintained premises.

The critical care services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed similar to the England average for all performance measures in the Intensive Care National Audit and Research Centre (ICNARC) 2013/14 audit. This meant the majority of patients had a positive outcome following their care and treatment. However, the target to admit 95% of patients within four hours of referral was not achieved. During April 2014 and March 2015 a total of 46 patients had been discharged during out-of-hours, compared to the hospital's target of zero out-of-hours patient discharges.

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. However, complaints raised by patients were not always resolved within the agreed timescales.

Outpatients and diagnostic imaging

Good

There had been improvements in the outpatients department since the last inspection. These included increased nursing staffing resulting in more clinics being available and additional out of hours clinics. There had been changes to the administration systems with additional roles and staff numbers which had resulted in better management of the waiting lists and improved communication with patients. The waiting times for

Summary of findings

an appointment from referral were better than the England average and plans were in place to improve this further. Policies and procedures were in line with recognised guidance and were up to date. There was effective multi-disciplinary working between local hospitals and between clinical specialists within the hospital.

Staff treated patients with respect, patience and kindness. They protected their privacy and dignity and provided support to them in a sensitive and discreet manner. Concerns were raised at the inspection on 29 April 2015 about some aspects of the resuscitation equipment and training. Changes to address these concerns had taken place at the unannounced inspection on 14 May 2015 with plans to make further improvements.

Despite a large number of improvements made in the past six months there was no formal audit programme in place to monitor the effectiveness of these changes. There had been changes in the leadership in the outpatient department and staff were positive about the improvements they had made. They felt increasingly able to contribute to the planning and delivery of the service, were included in joint working and described an increased team approach. However some staff in the diagnostic imaging service did not feel included in the changes that had been made or that they had led to positive outcomes for patients

Tameside General Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Outpatients & Diagnostic Imaging

Detailed findings

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Background to Tameside General Hospital

Tameside General Hospital is part of Tameside Hospital NHS Foundation Trust. Tameside General Hospital is situated in Ashton–under-Lyne. The hospital services a population of approximately 250,000 residing in the surrounding area of Tameside in Greater Manchester, and the town of Glossop in Derbyshire. In total, the trust has 524 beds and employs approximately 2,244.76 members of staff.

In 2013/14 the trust had 51,031 inpatient admissions, 252,074 outpatient attendances and 77,459 A&E attendances.

During this inspection, the team inspected the following core services:

- Urgent and emergency services
- Medical care services (including older people's care)
- Surgery
- Critical care
- Outpatients and Diagnostic Services

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Independent Specialist Clinical Advisor.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included a CQC inspection manager, four CQC inspectors, a CQC analyst, a CQC inspection planner and a variety of specialists including: Director of Clinical Service Development and former Medical Director; Director of Nursing, Clinical Services and MD of Community Health Services; Physician & Gastroenterologist; Matron trauma and orthopaedics; Clinical Director, Division of Emergency Medicine; Head of Nursing, Emergency Department / Acute Admissions; Consultant colorectal surgeon and former Medical Director; Theatre Co-ordinator; Consultant in anaesthesia and intensive care; Critical care Nurse; Consultant in clinical oncology; Outpatients nurse; Head of Outpatients; two experts by experience (lay members who have experience of care and are able to represent the patients voice).

Detailed findings

How we carried out this inspection

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

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

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

The announced inspection of Tameside General Hospital took place on 27, 28 and 29 April 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. Some people also shared their experiences by email or telephone. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We undertook an unannounced inspection between 4pm and 7.30pm on 14 May 2015. During the unannounced inspection we looked at the management and staffing of the acute medical unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Tameside General Hospital.

Facts and data about Tameside General Hospital

Tameside Hospital NHS Foundation Trust has only one location, Tameside General Hospital, currently registered with the Care Quality Commission. The hospital provides a full range of services including general and specialist medicine, general and specialist surgery and full Consultant led obstetric and paediatric hospital services for women, children and babies.

The hospital services a population of approximately 250,000 residing in the surrounding area of Tameside in Greater Manchester, and the town of Glossop in Derbyshire. In 2013/14 the trust had 51,031 inpatient admissions, 252,074 outpatient attendances and 77,459 A&E attendances. In total, the trust has 524 beds.

The health of the population in Tameside is generally significantly worse than that of the general population in England. Life expectancy for both males and females is significantly worse than the England average.

Tameside is ranked 42nd most deprived local authority (out of 326) and is in the most deprived quintile.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The urgent and emergency care department at Tameside General Hospital provides a 24-hour, 7 days a week service to a population of approximately 250,000 residing in the surrounding area of Tameside in Greater Manchester, and the town of Glossop in Derbyshire. It sees around 80,000 to 90,000 patients a year, approximately 200 to 250 patients a day.

We carried out our inspection on 28 and 29 April 2015. During that time we visited the resuscitation unit which had five cubicles, major injuries (majors) which had twelve cubicles and minor injuries (minors) units which had ten cubicles. We also visited the ambulatory care unit. There was a dedicated children's area with four cubicles.

We spoke with 11 patients or their family members and 19 staff including nursing, medical and ambulance staff. We reviewed 20 sets of patient care records. We reviewed national and local audit data and statistical information submitted by the trust, in order to enable us to reach a judgement on the services provided.

Summary of findings

In our 2014 inspection we rated urgent and emergency care services as good; but since that visit the CQC A&E survey showed the services as having the worst response in the country. We visited this service during this inspection to understand the reason for this change. It should also be noted that previously we were not confident that we were collecting sufficient evidence to rate effectiveness for urgent and emergency services. This has now changed and so during this inspection we also provided a rating for 'Effective'. As a result of this inspection we have rated the service as 'Requires Improvement'.

During this inspection, we found that learning from incidents was discussed by senior staff at clinical governance meetings. Although staff told us they received feedback relating to incidents they had personally reported; themes and trends of incidents were not consistently discussed at team meetings. There was a clear governance structure to identify risk and performance management. However, whilst the right structures were in place they were not fully embedded at the time of inspection to ensure robust learning and improvement. During our previous inspection we found that pain assessment and pain scores were not routinely carried out and recorded. During this inspection we identified the same concerns in relation to the timely assessment and administration of pain relief. Local and national audits had also identified that pain assessment and control was not

Urgent and emergency services

being managed appropriately. However, the action plans in place to address identified issues did not always include clear, measurable, specific actions and timescales. It was not clear how the successful implementation of these action plans was being monitored. As a result we were not assured that there were robust systems in place within the service to monitor and improve the quality and safety of services provided.

In the paediatric and 'resuscitation' areas of the emergency department we noted multiple omissions in daily stock check records of controlled medicines. In two records, the national early warning scores (NEWS) had been underscored. This could result in patients not being monitored or reviewed appropriately. Again the monitoring and recording of observations was identified as an area for improvement during the previous inspection. A maternal early warning system (MEWS) had been introduced but not all staff were aware of the form or had received training in its use. When reviewing care records we found two cases where vulnerable patients should have been referred to the safeguarding team and were not.

The emergency department was failing to meet many of the national access targets. For example, time to treatment and total time within the emergency department. However, the department was working closely with the local clinical commissioning group, the council, ambulance service and community partners to address admission avoidance schemes, to improve flow through the department.

Evidence-based care was delivered in line with National Institute of Clinical Excellence (NICE) and Royal College guidelines. We observed that staff were friendly, caring and responsive to patient's needs. Patients and relatives were complimentary about the staff, comments included, "They've been brilliant, not had to ask for anything."

Are urgent and emergency services safe?

Requires improvement

Learning from incidents was discussed by senior staff at clinical governance meetings. Although staff told us they received feedback relating to the incidents they had reported, themes and trends of incidents were not consistently discussed at meetings.

In the paediatric and 'resuscitation' areas of the emergency department we noted omissions in daily stock check records of controlled medicines. During our previous inspection we found that pain assessment and pain scores were not routinely carried out and recorded. During this inspection, we found pain scores had not been recorded and pain relief had not been prescribed and/or administered in a timely manner in 10 out of the 20 records we reviewed. In two records, the national early warning scores (NEWS) had been underscored. This could result in patients not being monitored or reviewed appropriately. A maternal early warning system (MEWS) had been introduced but not all staff were aware of the form or had received training in its use. Again the monitoring and recording of observations was identified as an area for improvement during the previous inspection. When reviewing care records we found two cases where vulnerable patients should have been referred to the safeguarding team and were not.

The decontamination room was being used inappropriately as a store room. We raised this with staff during our inspection and the room was cleared within 24 hours.

Incidents

- Staff understood how to report incidents via the electronic incident reporting system.
- Five serious incidents were reported from February 2014 to January 2015. All five incidents were related to pressure ulcers.
- Managers discussed learning and changes to practice through bi-monthly clinical governance meetings. We saw minutes of these meetings. For example, there had been an increase in incidents reported by the medical assessment unit relating to poor handovers from urgent and emergency care staff.

Urgent and emergency services

- Nursing and medical staff said they always received feedback from incidents that they had personally reported. However, learning from incidents and/or identified themes were not always discussed at meetings.
- Mortality meetings took place monthly, where multidisciplinary staff discussed patient deaths. The meetings identified the circumstances of the patient attending, the initial and follow-up care and treatment they had received and the circumstances of the death. We saw evidence of how learning from such situations was shared with the team.
- The clinical director gave us an example of how the trust had complied with the duty of candour regulations following a serious incident related to a pregnancy complication. We saw documentation of a full root cause analysis (investigation) including lessons learnt. The patient was fully informed of the results of the investigation and the learning that had occurred and was given the opportunity to ask further questions. The outcome of this led to the introduction of the pregnant person maternal early warning system (MEWS) being implemented.

Cleanliness, infection control and hygiene

- There had been no healthcare associated infections reported within the urgent and emergency services department between April 2014 and February 2015.
- We saw patients were cared for in a visibly clean and hygienic environment.
- Staff followed the trust policy on infection control and adhered to the 'bare below the elbows' policy.
- There were hand washing facilities and protective personal equipment (PPE), such as gloves and aprons, available. We observed and patients confirmed that staff used gloves and aprons when providing patient care.
- Hand hygiene and bare below the elbow audits in December 2014 demonstrated 100% compliance
- There were effective arrangements for the safe disposal of sharps and contaminated items; these included dating initial use of the sharp box.

Environment and equipment

- Most of the urgent and emergency department was spacious, well equipped and uncluttered. However, the decontamination room was cluttered and had been used for storage; it was not suitable for use as a decontamination room. This was escalated to the head of nursing and the room was cleared within 24 hours.
- There was a mental health assessment room with two doors, opening in and out. During our previous inspection in May 2014 potential ligature points had been observed. These had now been removed and the room was fit for purpose.
- Resuscitation equipment daily checks had been completed. We observed only two omissions in the records. This was an improvement on the previous inspection.
- We saw that electrical and maintenance checks had been completed on equipment appropriately.
- We saw that there was sufficient equipment available to staff in the Emergency Department (ED) to enable them to provide appropriate care and treatment.

Medicines

- Medicines were stored correctly in locked cabinets and fridges. Records showed that daily fridge temperatures had been monitored.
- Daily stock checks of the controlled drugs had been completed in most areas of the ED. However, there were omissions in records in the paediatric and 'resuscitation' areas of the ED. We looked at the records in the paediatric area between December 2014 and April 2015 and found six occasions when the record had not been completed. Within the resuscitation area we found five omissions.
- We performed random stock checks of the controlled drugs in relation to registers and found the stock levels matched what was recorded in the register.
- The majority of prescription charts (19 out of 20) were completed accurately.

Records

- We looked at 20 sets of care records during our inspection.
- We found the majority of records were completed accurately, were easy to follow, and were dated and signed. However, in 10 out of the 20 records pain scores had not been recorded. It was not clear whether this was because they had not been assessed or because the record had not been completed.

- Patient records were stored securely, easy to locate and we could easily obtain any notes we required when conducting our patient record reviews.

Safeguarding

- Staff had a good understanding of safeguarding procedures in relation to the protection of vulnerable adults and children. However, when reviewing records, we found two instances where vulnerable patients, one with a learning disability and one living with dementia had sustained a fall and bruising respectively, had not been referred to safeguarding. We escalated these cases to the senior medical consultant on duty. Staff were able to access the safeguarding policy on the intranet and received support from the trust safeguarding team.
- Staff told us they had received training in adult and children's safeguarding. Records demonstrated that 76% of doctors and 95% of nurses had received adult and children's safeguarding training.
- Staff had received training on safeguarding women and children with, or at risk of, female genital mutilation through their mandatory safeguarding training.
- The emergency department had access to senior paediatric opinion 24 hours a day for child welfare issues.
- The department had introduced a process whereby a safeguarding manager was allocated per shift to be 'on-call' to coordinate and respond to any safeguarding concerns that may emerge during each shift.

Mandatory training

- Staff told us they had completed their mandatory training. Records demonstrated that 93% of nursing staff and 100% of medical staff had completed their mandatory training. Mandatory training covered a range of subjects including manual handling, health and safety and infection control.

Assessing and responding to patient risk

- Patients presented to the department either by walking into the reception area or arriving by ambulance. Patients arriving on foot were seen at the reception by the receptionist who clerked the patient in. They were then seen by a nurse who triaged the patient within 15 minutes or sooner should the receptionist request it (the median time to be triaged was 5 minutes).
- Patients with minor injuries or ailments were seen and treated by the emergency nurse practitioner (ENP).
- Children were seen by either an advanced nurse practitioner in paediatrics or a doctor depending on their condition.
- Between July 2013 to January 2015 there were 32 black breaches at the hospital. 'Black breach' refers to failure to hand over a patient from the ambulance within 60 minutes of arrival at the emergency department. In the majority of cases, no reason was given for the breach. Nine breaches were due to complex clinical handover .
- Data submitted by the trust showed there had been 361 delayed ambulance handovers over 30 minutes between November 2014 and March 2015.
- The average time from ambulance to initial assessment was around eight minutes for most of the period April 2014 – March 2015. This was slightly longer (worse) than the England average, which was less than five minutes in the same period.
- Patients arriving by ambulance were assessed by a nurse, had their bloods and an electrocardiogram (ECG) taken and x-rays ordered. They were then changed into a gown and their identity band attached. The Rapid Access and Treatment team (REACT) led by a consultant would then rapidly assess all patients admitted to majors. The REACT team was available from 8am to 4 pm Monday to Friday. Outside of REACT hours, they would revert to the triage system. This meant that a nurse would do observations and prioritise according to clinical need.
- Patients arriving by ambulance as a priority call (blue light) were transferred immediately through to the resuscitation area.
- The department used the national early warning scoring system (NEWS) when assessing patients' level of risk. All the records contained NEWS scores. However, in two out of the 20 records, the NEWS score had been underscored. This could result in patients not being monitored or reviewed appropriately. (A NEWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically).
- The unit manager told us that the Maternal Early Warning System (MEWS) had recently been introduced to assess risks relating to pregnant women. However, not all staff were aware of this form and there did not appear to have been training for all staff prior to its implementation. This meant that there was the potential for inconsistent use of the forms.

Nursing staffing

Urgent and emergency services

- We observed that there was sufficient nursing staff to meet the needs of patients.
- Staffing levels were planned to ensure an appropriate skill mix to provide safe care and treatment for patients. There was 13 qualified nursing staff on the day shift between 7:30 am and 8 pm. The skill mix consisted of eight band 5 nurses, three band 6 nurses, one band 7 and two paediatric nurses. In addition Emergency Nurse Practitioners (ENP) worked between 7:30 am to midnight, with one ENP on the early shift and one on the late shift. There was also one trainee assistant practitioner on the early shift and one on the late shift. Three health care assistants also provided support.
- Training records showed that 92% of nursing staff had received training in resuscitation but it was not clear what percentage had received training in paediatric life support.
- At night between 7:30 pm to 8 am there was ten qualified staff, consisting of six band 5 nurses, three band 6 and one band 7. We saw nursing rotas which demonstrated these numbers of staff were adhered to.
- The unit manager informed us that they were reducing the use of agency staff within the department. We were told that wherever possible vacancies were covered by staff from within the department. Where agency staff were used they were given a full induction prior to commencing work.
- We observed a nursing handover. It included clinical details such as presentation, current clinical state, pain relief, specialty referrals as well as safeguarding requirements and overall state of the department.

Medical staffing

- There were seven full-time consultants, four of whom were trust employed locums, who worked between 8 am and 8 pm Monday to Friday. We were told by the clinical director that the locum consultants worked till 11 pm on most days Monday to Friday. An on-call service was provided between 11 pm to 8 am.
- At weekends the consultants worked 10 am to 6 pm with an on-call service overnight. Two middle grade doctors were on duty overnight.
- The service confirmed that all consultants received training in immediate paediatric life support.
- The department was funded for 17 middle grade doctors. Eight doctors were currently in post with the remaining vacancies covered through agency locums.
- There were 11 junior doctors consisting of one trust employed Clinical Fellow, five foundation year two doctors and five GP Vocational Training Scheme (GPVTS) trainees.
- Daily medical handovers took place at 12 o'clock and 4 pm. The emergency department nurse in charge attended these board rounds. The acute medical consultant also attended these rounds to identify suitable patients to be transferred to the ambulatory care unit.

Major incident awareness and training

- The major incident policy was available to staff in the emergency department and also on the intranet. Nursing and clinical staff were aware of the emergency planning procedures. Staff described how cards were available identifying specific roles if a major incident were to occur.
- Staff had received training in relation to chemical, biological, radiological and nuclear incidents.
- We asked staff to walk us through the care pathway if a patient presented with symptoms of Ebola. We saw that plans were in place to deal with such emergencies and staff understood how to follow them.
- There were three security personnel on-site who could be 'fast bleeped' in the event of an emergency. They regularly patrolled the hospital.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Evidence-based care was delivered in line with National Institute of Clinical Excellence (NICE) and Royal College guidelines. National and local audits were completed. However, some of the action plans to address the improvements required were not always specific or measurable.

Local and national audits demonstrated that pain assessment and control was not being managed appropriately. Similarly we found that in 10 out of the 20 records we reviewed, pain scores had not been recorded and pain relief had not been prescribed and/or administered in a timely manner.

Staff received training and were supported in their practice, with regular supervision and appraisals. However, one middle grade doctor was unaware of his responsibilities in relation to the Mental Capacity Act and Deprivation of Liberties. The trust had identified this as an area for improvement and had implemented a training programme for all staff and commissioned a specialist training programme to target clinicians. There was evidence of good multidisciplinary working within the department.

Evidence-based care and treatment

- Evidence-based care bundles were in use; for example for fractured neck of femur, sepsis, pneumonia, heart failure and stroke. These were based on National Institute of Clinical Excellence (NICE) and Royal College guidelines.
- Monthly audits were conducted to ensure adherence to these care bundles. Results of these audits demonstrated 89.4% compliance in January, 83.3% in February and 92.1% in March 2015. An action plan had been developed in relation to these results. However, the actions defined were not specific or measurable, for example it did not state specifically which care bundle improvement was required in and did not define what action was required to ensure all staff understood how and when to complete the care bundles. The action stated: "Ensure all staff understand importance of using care bundles."
- We witnessed a patient who collapsed in the waiting area and was subsequently treated for a stroke. They were treated appropriately according to national guidelines and transferred to a local stroke unit within 23 minutes.

Pain relief

- A local trust audit in January 2015 found that pain scores were not being routinely recorded and staff were not monitoring the effects of analgesia.
- The results of the national accident and emergency survey 2014 demonstrated that the department was performing worse than other trusts in relation to control of pain.
- Similarly we found that in 10 out of the 20 records we reviewed, pain relief had not been prescribed and/or administered in a timely manner and no pain scores were recorded.

Nutrition and hydration

- Most patients who attended the emergency department were seen and discharged before the need to consider nutrition and hydration. Patients attending the Minors unit had the option of using the vending machines in the waiting room for drinks and snacks.
- Healthcare assistants checked whether patients required food or a drink. They checked with a qualified nurse before providing food and drinks to patients.
- Patients and relatives told us that they had been offered food and drinks.

Patient outcomes

- The department had not achieved good outcomes in the College of Emergency Medicine (CEM) 2013/14 audits on paracetamol overdose and severe sepsis in septic shock.
- The department was rated worse than the England average for the following three components in the sepsis audit:

- Is there evidence that serum lactate measurement was obtained in the emergency department?

- Is there evidence in the notes of blood cultures were obtained and emergency department?

- Were antibiotics administered in the emergency department?

- Recommendations from the paracetamol audit included:

- Capacity to consent is recorded in every case of declined treatment where possible.

- ED (who take plasma tests levels earlier than 4 hours after ingestion should review their practice.

- ED should aim to treat patients with N-acetylcysteine within 8 hours of ingestion.

- Patients presenting after 8 hours ingestion who received NAC after 1 hour should be assessed and the reasons looked into.

- Action plans had been developed in relation to these audits but the actions were not always specific and measurable, for example one action stated: 'Provide junior doctor's training'. It did not specify details of the training the junior doctors required.
- The department had taken part in the 2013/14 CEM audit on moderate or severe asthma in children.

Tameside was within the lower quartile for recording peak flow and the Glasgow coma scale. These parameters are important as they are markers of severe acute asthma. While 100% of patients received treatment for asthma, only 2% received treatment within 10 minutes. The CEM standard for all children with moderate to severe asthma is to receive treatment within 10 minutes. This audit suggested that recognition of severe acute asthma may be delayed as a result of incomplete observations. An action plan had been developed in relation to the results which contained specific recommendations, actions and a re-audit date scheduled. However, the action planned was to participate in the development of the asthma care bundle in Greater Manchester. The timeline for this was six months. It was not clear what measures had been introduced in the interim to address these areas as both the detection and the treatment of asthma was below national norms.

- An action plan had been produced in response to the elderly care CEM audit. This contained specific actions and recommendations but no re-audit date planned to ascertain improvements.
- The unplanned re-attendance rate within seven days was worse than the national standard but similar to the England average between April 2014 and March 2015.
- Senior doctors reviewed the following patient groups prior to discharge:

-adults with non-traumatic chest pain,

-febrile children under 12 months

-unplanned readmissions within 72 hours

- This was in line with the Royal College of emergency medicine standards.
- Patients re-attending for a third time were reviewed by a consultant. This was a Tameside specific measure and was seen to be good practice.

Competent staff

- Nursing staff told us they had undergone appraisals with their line managers. They said these were effective; enabling them to highlight areas of interest and specialities which they wished to pursue. Records demonstrated that 63% of nursing staff and 75% of medical staff had received their appraisal (April to December 2014). The trust's appraisal process has been reviewed and was suspended in December 2014 supported by the board and was restarted in April 2015 with all appraisals expected to be undertaken by the end of August 2015.
- The Emergency Nurse Practitioners had a monthly programme of training provided by the consultants on subjects such as back and hip pain, ophthalmology, chest injuries and facial injuries.
- The level of medical supervision within the emergency department was good. They had staggered overlapped cover of middle grades up to 2 am in the morning. Beyond this there was always at least one middle grade within the department. This level of cover was appropriate for the department's size and activity.
- All the trainee doctors were subject to review by the Annual Record of Career Progression (ARCP), which ensured that their need for revalidation was met.

Multidisciplinary working

- Doctors reported good working practices in relation to multidisciplinary working. They told us the medical and surgical teams were very responsive when referrals were made.
- When required doctors from other specialities came to the department and saw patients, for example we saw an obstetrician seeing a patient.
- The trust had an alcohol liaison service which patients could be referred to if required.
- One of the consultants told us there was good access to psychiatric input. The psychiatric liaison nurses were frequently in the department and when elsewhere in the hospital, were responsive within 15 to 20 minutes.
- The System Resilience Group (SRG) involving representatives from the Clinical Commissioning Group (CCG), the local Council, the hospital and the ambulance service met to discuss admission avoidance schemes, patients who regularly attended, plans for winter pressures and how to cope with seasonal fluctuations.

Seven-day services

- The emergency department was open seven days per week and 24 hours a day.
- Radiology and pharmacy services were also available 24 hours a day seven days a week.

Access to information

Urgent and emergency services

- Information including care and risk assessments and test results were available to staff to enable them to deliver effective care and treatment.
- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust and access guides to policies and procedures to assist in their role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff had a good understanding of the Mental Capacity Act 2005 and were able to describe how to assess capacity and what actions to take when patients lacked capacity.
- However, one middle grade doctor we spoke with was unaware of his responsibilities in relation to the Mental Capacity Act. The trust had identified this as an area for improvement and had implemented a training programme for all staff and commissioned a specialist training programme to target clinicians.
- Staff were aware of assessing children using Gillick competency principles.
- Patients told us staff sought consent before carrying out procedures.

Are urgent and emergency services caring?

Good

We observed that staff were friendly, caring and responsive to patient's needs. Staff were cheerful and had a good rapport with patients. We observed positive interactions where staff treated patients with compassion.

The Friends and Family test response rates had increased from 26% to 44% between July 2014 and March 2015. Positive results where patients and relatives would recommend the service to friends and family had increased from 48% to 84%. Patients and relatives we spoke with were complimentary about the staff. One patient told us: "They've been brilliant, not had to ask for anything." Another patient said: "They are caring, I feel safe here."

We observed and patients told us that their privacy and dignity was always maintained. Patients and their relatives were kept fully informed about their care and treatment.

Compassionate care

- We observed that staff were friendly, caring and responsive to patients' and their relative's needs.
- We observed and patients told us that their privacy and dignity was maintained. Privacy signs were used on curtains to prevent staff from entering and we saw staff check before they entered cubicles.
- Patients and relatives were complimentary about the staff, comments included: "Staff are well mannered and I feel well-respected"; "They have been brilliant, not had to ask for anything" and "Staff are very friendly."
- We saw that staff were cheerful and had a good rapport with patients. We observed positive interactions where staff treated patients with compassion.
- The Friends and Family test response rates had increased from 26% to 44% between July 2014 and March 2015. Positive results where patients and relatives would recommend the service to friends and family had increased from 48% to 84%.
- The service received poor results in the A&E survey 2014. The service scored worse than the England average for 22 out of the 24 questions. We discussed this with the head of nursing who explained that following the results there had been a staffing review. It was found that they were using up to 20% agency staff. More permanent staff were recruited reducing the number of agency required. They felt this had helped to increase standards within the department. Staffing rotas demonstrated that there had been a reduction in the use of bank and agency staff.

Understanding and involvement of patients and those close to them

- Patients and relatives told us that staff gave full explanations about their care, any medication prescribed and follow-up care once they returned home. One patient said: "They explained everything and then get you to repeat it back to ensure you understand."
- We observed a doctor explaining the plan of care to a patient and a nurse explaining medication to another patient.
- Patients told us that they had been given written information to take home, for example a leaflet on head injuries.

Emotional support

Urgent and emergency services

- We observed staff to be warm and sensitive to both patients and relatives.
- Patients told us that they felt well supported and cared for. One patient said, “They are caring, I feel safe here.”

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

Requires improvement

During the previous inspection, we found staff were working hard to improve the flow of patients through the department. Overall the trust was meeting its quarterly access targets and there had been a reduction in ambulance turnaround times in excess of 30 minutes.

During this inspection however, we found the emergency department was failing to meet many of the national access targets. For example, time to treatment and total time within the emergency department. However, the department was working closely with the local clinical commissioning group, the council, ambulance service and community partners to address admission avoidance schemes and improve flow through the department.

Learning from complaints was discussed at governance meetings and disseminated to staff by their team meetings.

Service planning and delivery to meet the needs of local people

- The System Resilience Group (SRG) had representatives from the local clinical commissioning group (CCG), the Council, the hospital and the ambulance service. This group reviewed winter pressure schemes, admission avoidance schemes and patient ‘regular attenders’. They were looking at a service whereby the locum out of hours doctors assess patients in care homes to see if they are appropriate for admission prior to being transferred via ambulance.
- The emergency department (ED) was working with the CCG to review the elderly, frail care pathway. They were introducing community geriatricians to visit nursing homes to provide advice, to avoid admissions for example inappropriate admissions of end of life care patients.
- The ED was also working with the CCG and local community partners to coordinate systems to discharge patients back to community services to avoid admission when not necessary, for example mental health patients.
- An acute medical physician worked half the time within the emergency medical assessment unit and half within the emergency department to see which patients were suitable for discharge.
- The trust had introduced an alcohol liaison service as they had established that their local community had higher than average alcohol problems.
- The ED was working with the voluntary sector to see how they could support patients. They had made plans for volunteers to attend ED for three days in May, to signpost patients to appropriate services, for example substance misuse, befriending services and transport services to take people home.

Meeting people’s individual needs

- Translation services were available to assist staff communicating with people whose first language was not English.
- For patients with a learning disability, staff were able to access support from a specialist learning disabilities nurse. These patients may be known to the department and an alert was put on their notes to notify staff of their specific needs. Staff explained that they would use patient’s health passports which contained specific information about how the individual would like to be cared for.
- Support was available to staff caring for people living with dementia via a specialist dementia nurse.
- Patients with mental health needs were identified at triage and there was a room for these patients to be assessed.
- There was a dedicated children's waiting area available between 8 am and 10 pm which contained toys and activities to occupy them.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. The trust had a mixed performance against this standard over the period January 2014 to January 2015. Performance declined over the winter period, and they had regularly not achieved the standard since December 2014.

Urgent and emergency services

- For 2014/15 the trust had met the target for quarter one (achieving 95.6% overall). However, the trust had performed slightly worse than the target by the end of quarter two achieving 93.2% overall and also in quarter three achieving 93.4%.The trust failed to meet the target again in January 2015, achieving 89.2%
- The percentage of emergency admissions via ED waiting 4 to 12 hours was generally in line with the England average for the period March 2013 to January 2015.
- The average time to treatment was longer (worse) than the standard 50 minutes for the period April 2014 to March 2015 and longer than the England average over the same period.
- The unplanned re-attendance rate was higher (worse) than the standard for the period January 2013 to March 2015 but similar to the England average.
- The proportion of patients leaving before being seen was generally worse than the England average over the period January 2013 to September 2014.
- The total time in ED per patient was worse than the England average over the period January 2013 to September 2014, and generally over 170 minutes compared to the England average of around 130 minutes.
- Operational status, including breaches (and those about to breach) was discussed at nursing handover.
- The ED had an escalation policy and procedure in the event that the department became full. Senior staff were able to explain these procedures.

Learning from complaints and concerns

- Posters were displayed within the department explaining how to make a complaint. Patients we spoke with were aware of how to make a complaint.
- Learning from complaints took place at bi-weekly governance meetings and the weekly nurse meetings. Staff told us that they had received complaints regarding lack of information about waiting times. To rectify this they had now installed a board within the waiting area recording the current waiting time.

Are urgent and emergency services well-led?

Requires improvement

During the previous inspection we found there was good local leadership within the department and there had been a positive change in the culture of the department.

During this inspection, we found there was still evidence of clear nursing and medical leadership within emergency and urgent services. There was a clear governance structure to identify risk and performance management. However, whilst the right structures were in place they were not fully embedded at the time of inspection to ensure learning and improvement. During our previous inspection we found that pain assessment and pain scores were not routinely carried out and recorded. We identified the same concerns in relation to the timely assessment and administration of pain relief during this inspection. Local and national audits had also identified that pain assessment and control was not being managed appropriately. However, whilst action plans were in place they did not always include clear, measurable, specific actions and timescales. It was not clear how the successful implementation of these action plans was being monitored. As a result we were not assured that there were robust systems in place within the service to monitor and improve the quality and safety of services provided.

Staff spoke of a positive culture where they were encouraged to report incidents. Staff reported a friendly and supportive environment to work in. The department had implemented some innovative practices to improve the flow and effectiveness of care delivered. For example it had increased the number of emergency nurse practitioners who had been trained to work autonomously with the 'Minors' stream of patients.

Vision and strategy for this service

- Senior managers including the head of nursing and the clinical director for urgent care described their strategy which involved ensuring that the emergency department was appropriately staffed with an adequate

skill mix. The number of consultants and middle grade doctors had reduced and therefore they had increased the number of emergency nurse practitioners and advanced nurse practitioners within the department.
- Staff said they had been consulted over the development of the trust's values and felt that they were able to contribute to these.

Governance, risk management and quality measurement

- Bi-weekly clinical governance meetings were held. At which risks, incidents, complaints, performance against targets and results and action plans of local and national audits were discussed.
- Performance meetings took place for the band 7 and 6 nurses with the emergency department manager and matron on a weekly basis. The risk register was discussed at these meetings. The risk register reflected the issues we found such as breaching the four hour target.
- However, whilst the right structures were in place they were not fully embedded at the time of inspection to ensure robust learning and improvement. For example, themes and trends of incidents were not consistently discussed at team meetings.
- During our previous inspection we found that pain assessment and pain scores were not routinely carried out and recorded. We identified the same concerns in relation to the timely assessment and administration of pain relief during this inspection. Local and national audits had also identified that pain assessment and control was not being managed appropriately. However, the action plans in place following audits did not always include clear, measurable, specific actions and timescales. It was not clear how the successful implementation of these action plans was being monitored.
- Similarly, the College of Emergency Medicine Audits from 2013/2014 had identified areas for improvement in relation to sepsis and whilst action plans were in place, they did not stipulate clear, defined actions and timescales.
- As a result we were not assured that there were robust systems in place within the service to monitor and improve the quality and safety of services provided.

Leadership of service

- There was evidence of clear nursing and medical leadership within the emergency department.
- Both medical and nursing staff felt well supported by their managers.
- One doctor told us: "The clinical management and leadership is very apparent, there is always someone to discuss patients with." Another doctor said: "There is good leadership; we get support from both consultant and executive level."
- Staff told us that the executive team such as the medical director, chief nurse and CEO were visible within the department.

Culture within the service

- Staff spoke of a positive, open culture in which they were encouraged to report incidents.
- Staff told us they enjoyed working within the department. One doctor said: "It is a nice working environment and friendly." One of the Emergency Nurse Practitioners (ENP) told us: "It is a good department, well led and open to change and different ways of working."

Public and staff engagement

- The emergency department had worked hard to increase the response rates from the Friends and Family questionnaires. Feedback boxes and posters stating 'Your opinion counts' were in all areas of the department.
- There was a Friends and Family champion and health care assistants encouraged people to fill out the questionnaires.
- The Friends and Family test response rates had increased from 26% to 44% between July 2014 and March 2015. Positive responses whereby patients and relatives would recommend the service to their friends and family had increased from 48% to 84% between July 2014 and March 2015.
- Staff told us they received an emergency department newsletter containing complaints, compliments and how the department was performing.

Innovation, improvement and sustainability

- We spoke to senior managers about areas of innovative practice that had been implemented.

Urgent and emergency services

- They were proud of the expansion of the ENP service which had increased to eight ENPs. The ENPs had been trained to work autonomously within the 'Minors' stream of patients.
- The department had introduced a nurse led REACT service to try and reduce handover times from the ambulance service.
- Partnership working with the local police force had produced a range of initiatives to ensure that complex patients with a mental health condition or high-risk cases were appropriately and safely managed. 'Missing Patients Guidance' had been produced to reduce the number of missing patients leaving the hospital.
- A librarian attended the board rounds. They accessed evidence-based research to feedback to questions posed by the trainee doctors. This information was then published on the ED webpage.

Medical care

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

Information about the service

Adult medicine is part of emergency services and critical care division and the medical care services are provided within the Tameside Hospital location. Medical Care services are provided from eleven wards including a medical assessment unit (MAU) providing nearly 300 beds. Two wards particularly focus on patients living with dementia.

Data shows that for the period July 2013 to Jun 2014 adult medicine services had 22,213 spells of admission. This placed it in the lower quartile compared with other trusts. The types of spells comprised of 78% emergency, 1% elective and 21% day cases. By speciality 11% were categorised as 'other', 55% were geriatric medicine, 9% were gastroenterology and 75% were general medicine.

In May 2014 we carried out an announced inspection and rated medical services as 'requires improvement' overall. We rated Safe as inadequate; Effective as required improvement; Caring as good; Responsive as required improvement and Well Led as required improvement.

During our announced inspection on 28 and 29 April 2015, we visited the medical care services to see what progress had been made. We visited six wards including the Medical Assessment Unit (MAU). We also visited the MAU in the evening on 14 May 2015 as part of our unannounced inspection. During the inspection we spoke with 26 patients and relatives and 28 staff across a range of roles within medical care services including porters, nurses, matrons and consultants. We looked at patient records and reviewed information about the trust.

Summary of findings

In 2014 we found the quality of patient safety was inadequate to protect people from avoidable harm. Our inspection in April 2015 found significant improvements. These included systems to manage and monitor safety that all staff contributed to and a culture of improved openness among staff to report mistakes and incidents. There were arrangements in place for the service to learn when things go wrong. Staffing levels had been reviewed and improved.

We found that although significant changes had been made to improve the effectiveness of services, further improvement was still required. Nursing and medical staff had the skills they needed to carry out their roles effectively and they worked well together including across different roles. However the service performed almost consistently worse than other trusts across a number of outcome indicators during 2014. This meant that outcomes for people were below expectations compared with similar services.

Access and flow within medical care services remained an ongoing challenge. Local managers told us that patient flow through the hospital and discharge had improved but they were aware of improvements that still needed to be made. Due to bed pressures there were occasions when patients had been transferred from the MAU during the night and outliers were still common place. In such instances, the hospital had

Medical care

systems in place to ensure the timely review of these patients. However, we found there was no specific policy for transfers at night although ward managers told us they tried not to do so.

There were good systems, facilities and staffing skills in place to respond to the needs of patients living with dementia. People told us they were well cared for and staff were kind to them and staff responded compassionately when people needed support to meet their basic personal needs with dignity.

The executive team, including the chief nurse were visible and leading on a clear vision for change and improvement. The hospital was in the process of reviewing how services provided in the future would look and as a result this impacted on the ability of medical services to develop a long term strategy. However, local leaders were clear about the challenges and were able to identify significant developments which had contributed to improved patient care.

Are medical care services safe?

Good

Openness and transparency about safety was encouraged and staff were committed to this. There were robust systems in place to report incidents and learn from when things went wrong.

There were good systems in place for infection control and staff were committed to these in practice. Staff were aware of and understood their responsibilities in respect of safeguarding people from abuse. The systems and processes in place were embedded and implemented as part of everyday practice within medical care services.

Staffing levels and skill mix had improved since our last inspection in May 2014 and we found a responsive system in place to monitor and review staffing on a daily basis according to the needs of the current patients. However, there was still a reliance on the use of bank and agency staff to cover shifts.

Incidents

- The trust reported 22 serious incidents in this core service between February 2014 and January 2015. Twelve of the serious incidents were grade three and four pressure ulcers, and seven were Clostridium Difficile (C.Diff) and other health care acquired infections. All serious incidents were subject to investigation and action plans were in place where learning and improvement had been identified.
- Local managers in medical care services confirmed that incident reporting had improved among staff although this had created further work for ward managers as they had to provide staff with feedback when an incident was reported.
- There were systems in place including computer software to report and to learn from incidents. We saw examples of how these systems operated at ward level and connected with the Board.
- Ward managers received a copy of all incident forms submitted through the trusts electronic reporting system. Root cause analysis was undertaken if the incident involved harm.

Medical care

- Safety and quality rounds were conducted every day by senior nurses and matrons and their findings were recorded. Local managers confirmed that they held 'learning from experience' meetings once each month. Nominated patient safety officers had been put in place.
- The hospital had a number of policies and procedures that combined to set out its openness policy. Staff told us that the culture in the trust was much more 'honest' than it used to be. One member of staff told us: "There are incident forms, regular meetings; we have to report everything to matrons".
- We found that although the duty of candour responsibility was known in principle, staff did not know how to access the policy or procedure and had not received training at the time of our visit.
- We looked at ward records of an incident where a patient had suffered harm and noted that although it was investigated, there was no evidence at ward level of a duty of candour trigger and the ward manager did not know where to find the trust policy to check what the next step should or may have been.
- Mortality meetings took place monthly and reviewed all patient deaths that had occurred. The meetings were attended by all members of the multidisciplinary team and identified lessons learned. We saw evidence of how learning from such situations was shared with the team.

Safety thermometer

- Safety thermometer data submitted by the trust and collected nationally showed there were 17 pressure ulcers, 17 falls and nine catheter associated urinary tract infection levels (CAUTIs) reported by the medical care services between December 2013 and December 2014.
- It also showed there had been a rise in the prevalence rate of falls since July 2014. However, the trust told us that it undertook a weekly point prevalence audit of falls and reported that the rate of falls with harm had consistently been less than 1% since June 2014. The trust had an ongoing falls prevention plan in place, which included the implementation of the Falling Leaf campaign to raise staff awareness of patients at increased risk of falls. The falling leaf, a pictorial indication of patients at risk of falls, served as an additional layer of communication that will enable ward staff to easily identify this high-risk group.
- We noted safety thermometer results displayed conspicuously in each ward that we visited. These included use of the safety cross to display recent dates of falls incidents.
- A ward manager told us she believed the 'measles' system provided a more effective record system as it gave a clearer picture of where the falls were occurring on the ward. This system was about to be introduced as part of the trust response to the need to reduce falls.
- Falls that caused harm were investigated through root cause analysis (RCA).
- We looked at a report of a fall that caused harm on one of the medical wards. We noted the risk assessment for the patient had indicated that they needed a level of staff supervision that was not available on the day they fell. The investigation however, conducted by the trust's falls prevention team, concluded that therefore the harm was 'unavoidable'. This conclusion suggested that the RCA was not as effective as it should be and may not be successful in identifying key issues relating to the reduction of falls.

Cleanliness, infection control and hygiene

- There were seven C. Diff and other health care acquired infection incidents in medical care services between February 2014 and January 2015.
- The trust had policies and procedures in place for infection control.
- We noted that where patients were in isolation cubicles to control the spread of infection, staff followed infection prevention and control precautions properly.
- There were systems in place to identify areas and equipment that had been cleaned and were ready for use.
- Local managers told us that each ward had a housekeeper on duty weekday mornings and a cleaner on duty seven mornings a week. Toilets were cleaned again every evening. We noted that ward kitchens were also clean and fridge temperatures were checked and recorded regularly.
- We observed auxiliary staff deep cleaning rooms including the beds.
- Hand washing facilities were prominently positioned in the main foyer of the building with an announcing system to alert people passing to wash their hands.

- We saw staff in all roles regularly cleansing their hands on wards. Good supplies of aprons and gloves were available on the wards we visited and we saw most staff on duty using them.
- Staff complied with the trust's policy of bare below the elbows in all clinical areas. However we did observe some nursing staff required prompting by their colleagues or by our presence to put on a protective apron when caring for a patient.
- Records of regular hand hygiene audits supported high compliance among ward staff. Matrons confirmed that hand hygiene was peer reviewed between them.

Environment and equipment

- The environment appeared clean and generally uncluttered. We did find some accumulated dust on a light fitting in one ward which suggested that some high level cleaning was not always effective.
- Equipment was labelled and was cleaned and maintained appropriately.
- Resuscitation equipment was complete, clean and checked daily.
- Staff raised no issues about the availability and maintenance of equipment.

Medicines

- Patients told us they received their medication regularly.
- The trust told us it used the Medication Safety Thermometer which involved auditing all patients on eight medical and surgical wards on one day each month across a range of safety indicators, including medicines reconciliation and omitted doses. Benchmarking of the omitted doses demonstrated good compliance. The percentage of patients in MAU however who have had medicines reconciliation completed within 24 hours of their admission between April and December 2014 exceeded the target of 95% for five months but dropped below 85% for three months.
- We observed nurses following the trust's safe medicines management policy and procedures on the wards we visited. These included the wearing of a red tabard for the medication round indicating they should not be distracted from their task.
- Data shared with us by the trust prior to our inspection showed an upward trend of medication incidents. This showed there had been an improvement in staff reporting all medication management incidents and near misses. For example, we noted that unplanned omissions in providing patient medications was designated as a 'red flag' event that required staff to submit and incident report.
- Between 1 July and 30 September 2014, a total of 90 medication incidents were received by the Quality & Governance Unit. 36 of these occurred within the medical care department, all were rated as either insignificant or minor in outcome.
- Between 1 October and 31 December 2014, a total of 115 medication incidents were received by the Quality & Governance Unit, 53 of which occurred in the medical care department, all were rated as either insignificant or minor in outcome.
- Local managers told us that delays in obtaining take home medication for patients remained a challenge for the service.
- We noted from the Medication Safety Committee action plan of February 2015 that the trust was addressing this.

Records

- Trust policies and procedures were available to all staff on the trust intranet.
- The trust used an electronic system to record patient progress through the department. Junior doctors told us they were well supported clinically by the 'tracker' software.
- We saw clear, well organised, up to date and legible records on each ward that we visited.
- Local managers had systems in place for paper information, guidance and treatment tools that staff had easy access to.
- We looked at the notes of eight patients across three wards and found they each had clear records of assessment and treatment. The records contained nursing notes, medical notes, prescriptions and relevant care plans. All were legible and completed.
- One patient admitted through the emergency department, had no entry in their medical notes over their weekend stay in the MAU. This may have been because no particular issues were identified but this was not made clear.

Safeguarding

- We noted that the contact details for the safeguarding adult's manager were prominently displayed on wards where both staff and visitors could see them.

- In staff areas this information was displayed with a procedure flow chart.
- Ward staff including nursing auxiliaries understood their responsibilities to report any concerns they had about patients. They confirmed that they received safeguarding training. Data showed that compliance for completion of adult safeguarding e-learning during the previous 12 months was below the trust's own target of 95% for all staff roles except allied professionals. Nursing staff were the lowest compliance rate at only 65.3%.
- We observed some staff and local leaders responding to patient behaviour that challenged them and found that they behaved and managed situations in ways that supported people's rights but some interpersonal skills could be improved.

Mandatory training

- Mandatory training completion varied for both medical and nursing staff with some areas well below the trust target of 95%. For example, 88.9% (Medical staff) and 63.2% (nursing staff) had completed infection prevention and control e-learning whilst 100% (medical staff) and 83% (nursing staff) had completed health and safety e-learning. Local mangers told us that mandatory training for nurses was improving with a system of red/amber/green in use to highlight compliance and time built in to working schedules to enable staff to attend.

Assessing and responding to patient risk

- We observed that the National Early Warning System (NEWS) was well established on the wards. Local managers told us that this had been in place for four months at the time of our inspection.
- Nursing staff confirmed that a patient whose condition was found to be deteriorating could be escalated to the outreach team if required.
- Matrons told us that nursing staff would bleep them or a senior sister if a patient was deteriorating over a weekend. They had no difficulty then calling out a consultant. A member of staff told us: "Our relationship with consultants has changed massively".

Nursing staffing

- All wards that we visited were well staffed and there were few staffing vacancies. Where a nurse manager post was vacant for a ward, two other senior nursing grades were acting up to provide the relevant cover.
- We found flexible arrangements in place to ensure sufficient staffing to meet the needs of the current patients.
- The quality safety round conducted by a band 7 nurse each evening included an assessment of the staffing levels required for the patients that were admitted. This resulted in staff being moved to ensure appropriate levels to meet the need. The assessment was stored electronically and copied to the director of nursing each evening and a night feedback plan was sent to ward leaders each morning.
- Nursing staff worked 12 hour shifts and the minimum nurse to patient ratio was in line with the standard of 1:8. Staff told us that this had improved from 1:9 but that 1:7 would be ideal.
- Ward managers told us that use of agency staff had reduced recently to approximately ten shifts per week, whereas six months ago it was more typically sixty shifts per week.
- However, data provided by the trust prior to our inspection showed that there were still areas within medical care services that relied on high bank and agency usage to cover shifts. For example, between 1 November 2014 and 31 January 2015 (62 days) 465 shifts in the MAU (54 bed) had been covered by bank or agency staff. The average for the number of shifts covered by bank or agency staff each day was seven. This number peaked in November 2014 to up to 14 shifts in one day. During this period there were three or less bank or agency staff shifts on only 25 days.
- For the same period, on ward 44 which specialised in patients living with dementia and had 24 beds, the total number of shifts covered by bank or agency staff was 481. The average was five shifts in a day and the peak was 10 on three days in December 2014. During this period there were three or less bank or agency staff shifts on nine days and there was no day without a bank or agency staff cover shift.
- Sickness and other leave cover were provided by the national health services professions bank (NHSP). Staff were encouraged to register on NHSP and were then selected for duties at the hospital. The maximum number of additional hours worked was monitored.
- Wherever possible vacancies were covered by staff from within the department. Where agency staff were used they were given a full induction prior to commencing work.

Medical care

- During the announced part of our inspection we visited and noted the nursing staff levels in the MAU, wards 41 and 43 were adequate to meet the needs of the patients at that time.
- Several band 6 nurses had been recruited recently in the MAU.
- During our inspection, we received some information of concern about staffing levels in the MAU. We returned there during our unannounced visit to check it on 14 May 2015 at 5pm.
- The staff board for the night shift showed there were six nurses, which met planned numbers. There was seven nursing assistant staff on the night shift although the expected number was eight. One had been taken off the unit to support another ward; however the staff confirmed this did not impact on patients as the auxiliary staff floated between bays if needed.
- There were two nurses-in-charge and they were supernumerary.
- The trust had a system in place to risk manage the number of beds, including any additional beds, against staffing levels. This was a dynamic process through the daily bed management meetings.

Medical staffing

- During our inspection visit we noted the regular presence of consultants and junior doctors on the wards and in the MAU.
- We spoke with the consultant that had lead responsibility for rostering medical staff. He talked us through the roster demonstrating a much improved coverage at night times, weekend and bank holidays.
- He told us that adequate cover on a twilight shift had resulted in many fewer un-clerked patients being handed over to night shift staff.
- For the acute medical unit the consultant acute physicians had been increased from two in September 2014 to four.
- Physicians were supported by six junior doctors.
- Agency doctors were used to cover leave and could be used on call at night.

The trust had worked on standardising the clinical handover procedure on wards at weekends.

Major incident awareness and training

- Copies of the trust's major incident policy were available at ward level.
- The trust had circulated information to staff regarding Ebola risks and actions to take if a case was suspected.

Are medical care services effective?

Requires improvement

The trust routinely collected and monitored information about people's care and treatment and participated in national clinical outcome audits. However data showed that the service performed almost consistently worse than the English national average across a number of outcome indicators during 2014 including diabetes, heart failure and stroke care. This meant that outcomes for people were below expectations compared with similar services. Furthermore, our intelligent monitoring report highlighted the trust as being either a risk or an elevated risk for several mortality outliers and in-hospital mortality indicators including the Summary Hospital-level Mortality Indicator.

New models were being applied to ensure people's needs were assessed early and discharge was not delayed. At the time of our inspection it was too soon to judge their effectiveness but staff were confident these produced improvement.

Nursing and medical staff were suitably qualified and had the skills they needed to carry out their roles effectively and they worked well together including across different roles. People's consent to their care and treatment was sought and they were given information to make decisions. Proper arrangements were in place to consider 'best interest' decision making on people's behalf where necessary. Deprivation of liberty safeguards were recognised and embedded in the systems in place for safely managing wards.

Evidence-based care and treatment

- A locum specialist registrar demonstrated to us how staff accessed guidelines for acute medical patients on the trust intranet and paper copies of 'care bundles' for approximately nine conditions for example non-invasive ventilation.
- Care bundles, policies and procedures had been developed in line with national best practice guidance.
- We saw examples of good systems of local audit in practice. Local managers confirmed that they were

expected to complete a range of weekly audits, such as safety thermometer audits and submit reports to the matron. Action plans for improvement were overseen by the matron through monthly one to one meetings and reports were sent to the board.
- We noted the National Early Warning System (NEWS) was in use. This recently replaced a different system and staff told us it was therefore too early to audit its effectiveness.

Pain relief

- We looked at the notes of eight patients across three wards. These showed that patients were prescribed appropriate pain relief to meet their needs and this was monitored for efficacy. Patients confirmed that nurses regularly asked if they were comfortable and offered pain relief.

Nutrition and hydration

- Data provided by the trust showed it had rated itself as 'amber' against the 10 key characteristics of good nutritional care (Nutrition Alliance) and as 'green' against use of the malnutrition universal screening tool (MUST).
- We noted that wards operated a red tray system which identified patients who were assessed as being at nutritional risk and who needed support to eat and drink.
- We observed that patients had drinks available to them and within their reach.
- The trust performed worse than the English average for the majority of indicators in the National Diabetes Inpatient Audit (NaDIA) September 2013. In particular, the trust scored worse for "Staff knowledge – answers questions" (18.8% compared to the England average of 78.8%). This was also a decrease in the score they achieved in the 2012 survey (47.7%). It was not clear what action the trust had taken to improve as a result of this audit. However, the trust acknowledged that it had improvements to make against key characteristics of good nutritional care including diabetes care.
- We observed a meal service on wards and noted patients being given assistance by staff or family members.

Patient outcomes

- Our intelligent monitoring report highlighted the trust as being either a risk or an elevated risk for the following mortality outliers and in-hospital mortality indicators: Summary Hospital-level Mortality Indicator, gastroenterological and hepatological conditions and procedures, infectious diseases, conditions associated with mental health, nephrological conditions, vascular conditions and procedures. On request, the trust had provided the Care Quality Commission's outliers panel with the relevant information requested and could evidence that a full investigation had taken place to understand the mortality data and identify areas for improvement.
- The trust had a mortality steering group which met monthly. Since February 2014 a systematic review of all inpatient adult deaths had been completed. There was a Commissioning for Quality and Innovation (CQUIN) target for all eligible deceased patients' case notes to be triaged by senior nurses and clinicians led by the Quality and Governance Unit, and a mortality review to be completed within two weeks of the initial triage by a senior nurse/consultant/staff grade doctor. These cases were checked for coding accuracy with a senior coder. The clinical director for medicine told us the coding system was under scrutiny at the time of our inspection as the trust believed it was not coding all comorbidities for patients admitted.
- In December 2014, this trust was flagged as an elevated risk for the Sentinel Stroke National Audit Programme (SSNAP) Domain 2: overall team-centred rating score for key stroke unit indicator.
- The overall SSNAP (October 2013 to September 2014) level for the trust has been level D (second to worst) since January to March 2014, improved from E in October to December 2013 and the team centred rating for the key stroke Unit indicator has been at level E (worst) since October to December 2013.
- The trust Quality Account for 2014/15 reported 'a Greater Manchester Integrated Stroke Service (GMISS) was being introduced to provide a streamlined pathway of care to allow early admittance into specialist services for patients with suspected stroke, followed by continuing specialist acute care and rehabilitation, with adequate intensity, for as long as the patient benefits, and provide all Greater Manchester residents with equitable access to specialist stroke services'.
- Under these arrangements the trust will operate as a District Stroke Centre. It reports the trust intends to have the capacity and resource to receive patients from its own catchment population to enable service provision 7

days a week, for acute and rehabilitation stroke care. Specialist, seamlessly integrated stroke services will consist of an inpatient service and appropriate access to early timely supported discharge team and or a community stroke rehabilitation team.
- Key performance indicators have been agreed with GMISS to assure the quality of the service provided.
- To implement this The Trust has established an Executive Lead Stroke Strategy Group which is focused on improving the performance metrics related to stroke care.
- The trust performed worse than the England average for all the measures in the Myocardial Ischaemia National Audit Project (MINAP) audit 2013/2014. For example, 84.4% of nSTEMI patients were seen by a cardiologist (or a member of the team) compared to the England average of 94.3%. Only 7.3% of nSTEMI patients were admitted to the cardiac unit or ward compared to the England average of 55.6%.
- The trust performed worse than the England average for all of the In-hospital care measures and most of the discharge measures in the Heart Failure Audit 2012/13. For example, 73% of patients received an echocardiogram compared to the England and Wales average (91%). 42% patients received discharge planning compared to the average of 83%.
- The trust had put in place a plan with links to implementing NICE Quality standards. We noted minutes from the March 2015 meeting of the trusts Heart Failure Care Pathway Group. This work also linked to the Cardiology Improvement Programme and to the trust initiative of 'ensuring the right patient is in the right bed'.
- The average length of stay was longer than the England average for elective and shorter for non-elective admissions.
- The relative risk of readmission was similar to the England average for both elective and non-elective admissions in most specialties. However, it was over 30% higher for elective gastroenterology and almost 70% higher for non-elective clinical haematology. The trust told us they believed the issue relating to non-elective clinical haematology related to a small number of patients with follow-up of clinical complications from tertiary centres. A tertiary centre is a hospital that provides specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment.
- For general medicine wards the average length of stay for patients between July and December 2014 was generally just over seven days, with a drop in October and a rise in November 2014.
- The trust had a clinical audit policy and clinical audit primary and secondary action plans.
- A clinical audit and effectiveness group met regularly and included the medicine divisional governance lead and we noted minutes from a sample of meetings.
- We noted good examples of robust systems in place for consistently auditing and checking back for improvement on the delivery and quality of care on wards through senior nurses, ward managers and matrons.

Competent staff

- Junior doctors told us they were well supported by consultants and were given good access to teaching in protected time.
- Local managers confirmed that nursing staff could apply for special leave to extend their training and the trust usually granted the funding to pay for the course and qualification.
- Appraisals had been recently reorganised at ward level with the intention to appraise all staff between April and August 2015 and this meant the process had only just started at the time of our inspection.
- The trust performed within expectations for most of the areas in the 2014 GMC National Training Scheme Survey and the 2014 NHS Staff Survey

Multidisciplinary working

- The dementia care specialist nurse told us that there was good teamwork on the wards to support patients living with dementia. This enabled staff to provide better person-centred care in order to meet the needs of these patients.
- Ward managers said they felt well supported by consultants and junior medical staff.
- Junior medical staff told us they had a good relationship with nursing staff and ward managers left a list of jobs in the doctor's room which juniors attended to.

- We observed good, constructive, professional relationships between nursing and medical staff during our visits.
- We noted ward meeting minutes showed multidisciplinary working and shared learning.

Seven-day services

- Junior doctors told us they were happy with the extra middle grade staffing and the extra consultant arrangements that had been provided at weekends to see potential patients fit for discharge and sick patients.
- Gastroenterology ward senior nursing staff told us that over the weekends the consultants on call for the wards would see patients as required, if they are ready for discharge or sick for which the team would have left a care plan. Staff told us: 'the gastroenterologists are very helpful and can be contacted on their mobile phone if need be'.
- The service was working towards having two ambulatory advanced nurse practitioners working three day shifts in order that the ambulatory service could be provided over six days. This was expected to be in place within a few months after our inspection with a long term plan to have a seven day ambulatory service.

Access to information

- We noted policies and procedures on wards in places where staff could access them, for example the clinical manager protocol for suspected C. Diff was on a wall. Staff confirmed that they also went to the trust intranet site for information. When we tested this out we found that staff knew how to navigate to policies and procedures quickly.
- Other types of information were available to staff to enable them to provide person centred care such as a catering booklet that contained a lot of helpful advice.
- We noted patient information leaflets at bedsides.
- There was a patient tracker system that all staff could access to see the progress of care and treatment for any patient at any given time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff assessed patient capacity and sought consent in accordance with legal requirements. If patients lacked the capacity to provide informed consent, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- Patients told us that they were kept informed about their treatment plans and doctors explained to them what the options were.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). We saw several examples of DoLS paperwork completed fully and accurately.

Are medical care services caring?

Good

People told us they were well cared for and staff were kind to them in adult medicine services.

Feedback regularly collected by the trust from patients and those close to them was positive about the way staff treat them.

Staff responded compassionately when people needed support to meet their basic personal needs with dignity. We found that staff helped people and their families to cope emotionally with their care and treatment.

Compassionate care

- The service had a higher response rate for the Friends and Family Test than the England average, and generally high scores for all wards between December 2013 and November 2014.
- The response rates for wards that specialised in caring for people living with dementia was more than three times higher than the national average.
- The friends and family test asks patients how likely they are to recommend a hospital after treatment. The majority of responses received between December 2013 and November 2014 in relation to medical care indicated that patients would recommend the service.
- We noted that the friends and family test results were visible and accessible to patients and relatives on the wall in wards.
- We noted that patients looked well cared for and were treated with dignity.

Medical care

- We observed that staff showed great interest in their patients and generally interacted with patients with kindness.
- Staff responded compassionately to patients to support them to meet their personal needs with dignity, for example we noted on wards that patients who were at risk of losing management of their continence were placed in beds nearest to the toilets.

Understanding and involvement of patients and those close to them

- All patients and family members that we spoke with told us they felt well looked after and staff understood their needs.
- The trust was piloting a scheme of open visiting on some wards. We noted for example that for one patient who was confused and highly challenging, their spouse was supported to stay overnight to help them cope with the unfamiliar environment of a hospital room.

Emotional Support

- We saw and heard a relative getting emotional support as well as practical help from staff with their spouse who was distressed and challenging them and the service.

Are medical care services responsive?

Requires improvement

Access and flow within medical care services required improvement. Local managers told us that patient flow through the hospital and discharge had improved but they were aware of improvements that still needed to be made. For example, they said they still needed to move toward a consultant review each day; it was currently twice a week. Due to bed pressures there were occasions when patients had been transferred from the MAU during the night and outliers were still common place. In such instances, the hospital had systems in place to ensure the timely review of these patients. We found there was no specific policy about transfers at night although ward managers told us they tried not to do so.

The trust had good systems in place to meet the complex needs of patients living with dementia. The facilities and premises provided were appropriate for the service being delivered. These had been improved and further staffed to respond to the needs of the local population and other stakeholders. Complaints were used as an opportunity to learn and bring about positive change.

Service planning and delivery to meet the needs of local people

- Greater Manchester Integrated Stroke Service (GMISS) was being introduced to provide a streamlined pathway of care to allow early admittance into specialist services for patients with suspected stroke.
- Local leaders told us that ward rounds had been moved from 9am to 10am so that that patients' personal care could be carried out first. This meant that patients could be clean and ready for the day before they saw their doctors and medical students.
- There was an ambulatory area in one bay near the entrance to and within the AMU female section. Patients were referred to this service by their GP. Ambulatory care provides a patient focused service where some conditions may be treated without the need for an overnight stay in hospital.
- Ambulatory care operated until 8pm. It was staffed by an advanced practitioner (AP) and two trainee AP's and one registered general nurse. They were supported by a medical registrar and a consultant.
- We noted information for patients and relatives about visiting and mealtimes was available at bedsides.

Access and flow

- Local managers told us that patient flow through the hospital and discharge had improved but they were aware of improvements that still needed to be made. For example, they said they still needed to move toward a consultant review each day; it was currently twice a week.
- We observed a medical ward round and noted that the SHOP (sickest, home, other patients) model was applied. Local leaders told us this had been recently introduced and it improved patient flow through and out of the hospital.
- The bed management record for 29 April 2014 at 08.30am demonstrated the system in place to monitor patient flow throughout the hospital including through the MAU and medical wards. We tracked the care of two patients through from admission from the emergency

department to the AMU and on to specialist wards. From looking at their notes and records and speaking with them or their relative we found that the process had been appropriate and safely managed.
- There was a board round on each ward once a day during the week. This operated on the SHOP method so that patients ready to be discharged were seen and discussed straight after prioritising the sickest patients.
- Nursing staff confirmed that any delays over the expected date of a patient's discharge were escalated to the patient flow coordinator.
- In 2013 to 2014, 8% of patients were moved two times or more during their hospital admission. This had since fallen to 6% between April and December 2014.
- Ward leaders on MAU told us they experienced no problem in transferring a patient to the correct medical ward according to speciality.
- On the 29 April 2015 eight medical outliers were recorded on the 08.30 bed management record.
- There was an additional medical registrar for overseeing the care of medical outliers and also a specific named consultant responsible for a patient depending on which ward the patient was placed. Junior doctors told us this was a good system to ensure medical outliers received appropriate care.
- We tracked a sample of these patients on to the wards they were admitted to and found they were receiving appropriate care and treatment as planned and were seen regularly by relevant consultants.
- There were no outlying cardiology patients at the time of our inspection and local leaders told us there was a capacity to flex five beds into use if pressures on cardiology bed increased.
- We received a complaint from a family prior to our visit about their elderly relative being moved between wards during the night.
- We found there was no data available on the bed management meeting record for 29 April 2015 at 08.30 for the number of patients transferred after 9pm although it was a question on the form.
- We asked the trust to provide us with this data for the period 21 to 28 April 2015. Trust data showed that there had been 79 transfers from the AMU between 10pm and 6 am during this week.
- Sixteen patients had been transferred to cardiology wards, however 22 had been transferred to elderly care wards including to the two specialist dementia care wards.
- We found there was no specific policy about transfers at night although ward managers told us they tried not to do so.
- Referral to treatment times (percentage within 18 weeks) for general medicine was better than the England average at 96.9% for April 2013 to November 2014.

Meeting people's individual needs

- We noted that written information was available to patients on wards in a variety of languages.
- The signage around the environment was clear and of good quality.
- There was a system in place for nursing leaders to book relatives into consultant's diary slots for meetings about their family member.
- We noted that there were two wards that were particularly adapted to meet the needs of patients living with dementia. For example, rooms were clearly labelled with pictures including toilets, there were large clocks strategically placed on walls and there was information for relatives and visitors to the ward including a film running about dementia on a monitor in the ward entrance.
- The trust had a dementia care specialist nurse in post who provided support to services across the trust, including medical care services. They were very positive about improvements on the wards for people with dementia since our last inspection. Other staff told us they highly valued the support of this specialist.

Learning from complaints and concerns

- We noted a very large poster with information about how to complain about the service in a main foyer.
- Complaints feedback was on display in wards in a 'you said; we did' display.
- One ward manager told us that the setting up of a 'learning from experience' meeting once each month where complaints were discussed, was one of the three improvements of which she was most proud.

Are medical care services well-led?

Medical care

Good

The executive team including the Chief Nurse were visible to medical care services and were leading on a clear vision for change and improvement. The hospital was in the process of reviewing how services provided in the future would look and as a result this impacted on the ability of medical services to develop a long term strategy. However, local leaders were clear about the challenges and were able to identify significant developments which had contributed to improved patient care.

There were good local systems in place on wards for identifying and managing risk. Processes were in place to provide reliable and timely information to manage current and future performance. The service was transparent, collaborative and open and local leadership was robust and prioritised safety. Staff at all levels were engaged with change and the trust and local leaders were working at more effective engagement with the local communities.

Vision and strategy for this service

- There was a clear purpose among staff at all levels to improve the quality of care consistently and the reputation of the hospital.
- Staff understood the trust's vision and values and how these impacted on the delivery of medical care services.
- The hospital was in the process of reviewing how services provided in the future would look and as a result this impacted on the ability of medical services to develop a long term strategy. However, local leaders were clear about the challenges and were able to identify significant developments which had contributed to improved patient care.
- Local managers told us that staffing still needed to improve in some areas although recruitment was getting easier as Tameside Hospital was gaining a better reputation than it had previously had.

Governance, risk management and quality measurement

- Local risks were managed and mitigated well and the appointment of matrons had had a positive impact but there was still a lack of formalised local strategy.
- Medical care services had identified the issues and recognised that there were still areas for improvement. Plans were in place to improve outcomes for some areas such as stroke/heart failure.
- There was a risk register system in place for identifying and monitoring each ward's management of risks and escalating these up through the trust. For example, we tracked how one incident raised an environmental safety issue on a ward that then went on to the ward risk register and was reviewed until the action was completed.
- Quality rounds were conducted on medical wards and the acute medical unit daily by matrons.
- Ward managers produced a weekly report for matrons on all incidents and complaints and these were followed up by an improvement plan that was reviewed in weekly meetings with a monthly review.
- Matrons checked weekly feedback from the ward managers round and were supporting new band 6 nurses to implement a new, hands on management approach to manage improvement closely for accountability. Formal performance management measures were followed if managers were not following through actions for sustained improvement.
- We tracked an example of an improvement plan in progress for one ward in March 2015 through records. The plan had been updated weekly following meetings with the matron and was reviewed monthly until all actions were completed. The ward manager was responsible for submitting a weekly 'quality and safety round summary' feedback sheet to the matron. These were checked against a weekly walk around the ward by the matron.

Leadership of service

- The trust appointed two new matrons during 2014, one to head up the urgent and emergency care service and the other to look after frail and elderly patients in the medical care division.
- Ancillary staff told us that there was good leadership on wards, people were directed and were clear about what they were doing.
- Newly appointed staff, including ward managers, told us they were well supported by their colleagues and senior managers.

- We saw evidence of clear oversight from local leaders on the quality of the service provided to patients.

Culture within the service

- Local managers told us that the trust executive team was very visible and had a lot of contact with staff when changes were planned.
- Some local managers were very positive about change. They said: "The hospital is unrecognisable from how it was two years ago, the culture is much more open. The management both middle and top tier are very approachable." However, others told us long serving staff still felt the 'old style of blame culture'.
- Staff at all levels and roles said that everyone was helpful and staff were supportive of each other for the benefit of patients.
- Newly appointed staff told us that Tameside hospital was more personal than larger hospitals they had worked in.

Public and staff engagement

- Staff at all levels were committed to improving the service and felt engaged with the changes that had been made and what still needed to be achieved.
- Matrons gave us an example of a relative's complaint about poor quality interactions because of staff fatigue. This brought about change and led to the introduction of 'Intentional Ward Rounding'; staff were involved in developing the tools and documents and this helped to bring about positive change.
- The trust website showed that on 9 May 2015 the first in a series of new community events was hosted by the trust. The aim of the event was to bring the hospital's consultants, nurses and healthcare professionals into the heart of the Tameside community to discuss and educate the public on specific conditions.

Innovation, sustainability and Improvement

- Matrons confirmed the trust's transformational plan included a commitment to achieve greater clarity about the focus and purpose of clinical handover, the board round and the multi-disciplinary team meeting (MDT) in order to avoid duplication.
- One improvement that was being worked on by Matrons was to shorten the MDT meetings.
- Local leaders told us they believed the improvements attained so far in quality care were sustainable in medicine because the trust had added a third matron post to the division.

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

Information about the service

The hospital provides a range of surgical services, including trauma and orthopaedics, oral surgery, ear, nose and throat (ENT), plastic surgery and general surgery (such as colorectal surgery). There are three surgical wards and 10 operating theatres that carry out emergency trauma and general surgery as well as some day case and elective surgery procedures. Hospital episode statistics data showed 15,016 patients were admitted for surgery at the hospital between July 2013 and June 2014. The data showed that 45% of patients had day case procedures, 12% had elective surgery and 43% were emergency surgical patients.

We visited Tameside Hospital as part of our announced inspection on 28-29 April 2015. We also carried out an out-of-hours unannounced visit on 14 May 2015. As part of the inspection, we visited the theatres, the day case unit, the surgical unit, the planned orthopaedic unit and the emergency orthopaedic unit.

We spoke with 11 patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, theatres staff, the clinical director for elective services and the divisional director of operations. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

During our previous inspection in May 2014, we found the surgical services at this hospital required improvement. During that inspection, we found improvements were needed in the processes for patient safety, effectiveness of treatments, responsiveness of the services and leadership and governance.

During this inspection we found that patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in clean and suitably maintained premises. Care and treatment followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. The staffing levels and skills mix was sufficient to meet patients' needs. Staff received mandatory training. However, the number of staff that had completed mandatory training was below the hospital's expected levels.

The majority of patients had a positive outcome following their care and treatment. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards. Patients spoke positively about their care and treatment and they were treated with dignity and

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compassion. The trust vision and values had been cascaded and staff understood them. The wards and theatres had clear and clearly visible leadership with clinical, nursing and business leads.

However, surgical services had failed to meet 18 week referral to treatment standards for ear, nose and throat (ENT) surgery and for trauma and orthopaedics during the past year. The plans to improve compliance included improved planning and theatre capacity and the use of external healthcare organisations to treat patients awaiting surgery. The rate of surgical site infections following fractured neck of femur (hip) surgery at the hospital was 4.7% between January 2014 and December 2014. This was worse than the national average of 1.3%. The action plan to improve surgical site infections included monitoring of patients temperature in theatre and additional training for theatres staff.

There were 550 operations cancelled between May 2014 and April 2015. The number of patients whose operations were cancelled and were not treated within 28 days was worse than the England average between October 2012 and September 2014. Theatre sessions were frequently delayed and started more than 15 minutes late due to patient management and surgeon or anaesthetist delays. The majority of complaints were not resolved and responded to within the agreed time frames.

Are surgery services safe?

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place for the escalation of patients whose condition was deteriorating. Patients' care was supported with the right equipment. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

Staff received mandatory training on a range of subjects such as moving and handling, safeguarding and infection control. However, the numbers of staff that had completed mandatory training was below the hospital's expected levels. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist and staff adherence to WHO guidelines was monitored through monthly audits.

However, the rate of surgical site infections following fractured neck of femur (hip) surgery at the hospital was 4.7% between January 2014 and December 2014. This was worse than the national average of 1.3%. The action plan to improve surgical site infections included monitoring of patients temperature in theatre and additional training for theatres staff.

Incidents

- The strategic executive information system data showed there were five serious incidents reported in relation to surgical services across the hospital between February 2014 and January 2015. This included two grade 4 pressure ulcers, one grade 3 pressure ulcer and two incidents relating to healthcare acquired infections.
- We saw evidence that these incidents were investigated and remedial actions were implemented to improve patient care. For example, staff on the emergency orthopaedic unit received additional wound care and pressure relief training during November 2014 and patient assessment forms and care plans were updated to assist staff in identifying patients with pressure ulcers.

- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority.
- Staff told us incidents and complaints were discussed during monthly staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at.
- The incident reporting system identified incidents that had led to serious or moderate harm to patients and prompted staff to apply duty of candour (being open and honest with patients when things go wrong). A ward manager gave an example where a patient experienced moderate harm as a result of a fall. A specialist falls nurse apologised to the patient and their relatives and explained what steps would be taken to address the issue.
- Patient deaths were reviewed by individual consultants within their surgical specialty area. These were also presented and reviewed at monthly governance meetings and hospital-wide monthly mortality steering group meetings.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- Safety Thermometer information between December 2013 and December 2014 showed there were five pressure ulcers, three falls with harm and seven catheter urinary tract infections reported by the hospital relating to surgical services.
- Information relating to this was clearly displayed in the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and five Clostridium difficile (C. diff) infections relating to surgery at the hospital between April 2014 and March 2015.
- We looked at the investigation report and action plan for a C. diff incident on the planned orthopaedic ward in January 2015. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- Public Health England data showed 4.7% of patients acquired surgical site infections following fractured neck of femur (hip) surgery at the hospital between January 2014 and December 2014. This was worse than the national average of 1.3%.
- We looked at the surgical site infection investigation report and action plan for a patient readmitted to the hospital with a surgical site infection in November 2014. This identified that National Institute for Health and Care Excellence (NICE) guidelines for surgical site infection were not always followed in relation to the monitoring and recording of patient temperatures during surgery.
- There was an action plan to improve surgical site infections. This included additional surveillance of the monitoring of patients temperature in theatre by the infection prevention surveillance nurse, additional training for theatres staff regarding the recording of patient temperature in theatre and recovery and the purchase of additional patient body warmer equipment for use during surgery.
- The wards and theatres we inspected were visibly clean. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a suitable supply of hand wash sinks and hand gels available. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.

Environment and equipment

- The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.

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- Equipment was appropriately checked and cleaned regularly and equipment had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment needed for surgery was readily available and any faulty equipment could be replaced from the hospital's equipment store.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit. Theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- Reusable endoscopes (used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room. We saw that scopes were decontaminated in accordance with best practice guidelines with a segregated clean and dirty area and use of a coding system for traceability. The facility was accredited by the joint advisory group for gastrointestinal endoscopy (JAG).
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines were ordered, stored and discarded safely and appropriately. Medical staff were aware of the policy for prescribing antimicrobial medicines.
- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- A pharmacist carried out daily reviews on each ward. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication charts for three patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- Staff used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for seven patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records up to March 2015 showed training completion rates for safeguarding children was 76.6% and 80.2% for safeguarding adults. Staff were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was clearly displayed in the areas we inspected. Each area we inspected also had safeguarding link nurses in place.
- Safeguarding incidents were reviewed by the departmental managers and also by the hospital's internal safeguarding board, which held meetings every two months.

Mandatory training

- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. Information on mandatory training performance was displayed on notice boards in each area we inspected.
- The majority of staff across the elective services division had completed their mandatory training. However, the hospital's internal target of 95% compliance in mandatory training had not been achieved.
- Records up to March 2015 showed the overall training completion rates were infection control (70.5%), information governance (76.6%), equality and diversity (89.8%), health and safety (87.2%), manual handling (71%) and resuscitation training (86%).

Surgery

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and matrons to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care.
- Staff used early warning score systems and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- Patient records showed that staff had escalated patients correctly, and repeat observations were taken within necessary time frames to support patient safety.
- We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- Staff carried out a fortnightly audit to monitor adherence to the WHO checklist by carrying out ad hoc spot checks and reviewing a random selection of completed checklist records. The audit records for April 2015 showed overall compliance ranged between 80% and 100% in key measures such as completion of records during the sign in, sign out and time out phases. Audit findings were shared with the theatre teams during safety briefs to aid learning.

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards, based on national NHS safe staffing guidelines and these were monitored monthly. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis. We found flexible arrangements were in place to allow staffing levels to be adjusted to meet the needs of the current patients
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients received the right level of care.
- Trust data showed that the vacancy rate for nursing staff across the surgical wards ranged from zero to 5.9% during March 2015.
- As part of the workforce plan the theatres department planned to implement sessions based on a 48-week schedule instead of the current 40-week schedule. The theatre coordinator told us this meant further recruitment was needed in order to maintain the staffing establishment. The theatre coordinator told us recruitment was on-going and eight additional newly qualified theatre nurses had been recruited over the past 12 months.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. Staffing levels were maintained by staff working overtime and with the use of agency staff.
- The ward managers told us they tried to use existing staff or regular agency staff that were familiar with policies and procedures. Where possible, temporary staff were accompanied by permanent trained staff so that patients received an appropriate level of care. Agency staff underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment.
- The majority of agency staff working in the theatres were long-term agency staff that had undergone induction training and were familiar with the theatre department's policies and procedures.
- The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that two patients showing confusion symptoms following surgery were provided with 1:1 nursing care.
- The ward managers were supernumerary and did not form part of the staffing establishment and this allowed them to carry out their management and administrative duties.

- Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Patients spoke positively about the staff and did not highlight any concerns relating to nurse staffing levels.

Surgical staffing

- The wards and theatres we inspected had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of middle career doctors and junior doctors within the trust was greater than the England average. The proportion of consultants was below the England average (35% compared with the England average of 40%). The proportion of registrars was also below the England average (20% compared with the England average of 37%).
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum and agency doctors had worked at the hospital on extended contracts so they were familiar with the hospital's policies and procedures.
- We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the surgical services. This listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected and staff were aware of how to access this information when needed.

Are surgery services effective?

Good

Surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. During 2014/15 Surgical services participated in 41 internal and national clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was similar to or better than the England average for all specialties except for non-elective trauma and orthopaedics. A planned review was scheduled for June 2015 to conduct a multidisciplinary external review of the hip fracture pathway by the British Orthopaedic Association to identify quality improvements in areas such as patient outcomes and rates of readmission.

Evidence-based care and treatment

- Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE). Emergency surgery was managed in accordance with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).
- Enhanced recovery pathways were used in a number of surgical specialities, such as orthopaedic surgery. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.

Surgery

- During 2014/15 the surgical services participated in 41 internal and national clinical audits. Surgical services had completed 13 of these audits to date with 22 audits currently in progress. The services participated in all 15 of the national audits for which the hospital was eligible for.
- Progress against the clinical audit plan 2014/15 and compliance with NICE guidelines was reviewed at monthly quality and governance board meetings.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at three policies and procedures on the hospital's intranet and these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- Patient records showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort. Patients told us staff gave them pain relief medication when needed.
- There was a dedicated pain team within the trust and staff knew how to contact them for advice and treatment when required.

Nutrition and hydration

- Patient records included assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, this was addressed by the medical staff to ensure patient safety. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that the surgical wards used a red tray system so patients living with dementia could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- The national hip fracture audit 2014 showed that the hospital performed better than the England average for six out of the seven indicators, including the number of patients admitted to orthopaedic care within four hours, the number of patients developing pressure ulcers, the number of patients that were assessed by an orthopaedic geriatrician and for total length of patient stay at the hospital.
- The hip fracture report highlighted that the hospital performed worse than the England average for the number of patients having surgery on the day of or after day of admission.
- The lung cancer audit 2014 showed the trust performed better than the England and Wales average for the percentage of patients having a CT scan before bronchoscopy and the percentage of patients receiving surgery in all cases. The trust performed worse than the England and Wales average for the number of cases discussed at multidisciplinary meetings (88.5%% compared with the average of 95.6%).
- The national bowel cancer audit of 2014 showed that the trust had performed better than the England average for case ascertainment rate, data completeness, the number of patients that had a CT scan, the number of patients for whom laparoscopic surgery was attempted, the number of patients that underwent major surgery and the number of patients seen by a clinical nurse specialist.
- The trust performed similar to the England average for the number of cases discussed at multidisciplinary team meetings (98.5% compared with average of 99.1%) but was worse than the England average for patient length of stay above five days (74.4% compared with the average of 69.1%).
- The national emergency laparotomy audit (NELA) report from May 2014 showed that 18 out of the 28 standards were met by the hospital. This included having a fully staffed emergency theatre available at all times, a care pathway for the management of patients with sepsis, a policy for deferment of elective activity to prioritise emergencies and policies for consultant surgeons and consultant anaesthetists to formally hand over in person.

Surgery

- During April 2015, the Royal College of Anaesthetists identified this hospital as one of the top 10 hospitals nationally for preoperative risk documentation and for a low rate of missing P-POSSUM data.
- The national joint registry (NJR) data between April 2003 and July 2014 showed that hip and knee mortality rates at the hospital were within the national average.
- Performance reported outcomes measures (PROMs) data between April 2013 and March 2014 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was similar to the England average.
- This hospital was flagged as an outlier in December 2014 for the PROMs EQ- 5D score for hip and knee replacements. However, the national joint registry data and other PROMs measures for hip and knee replacements (such as Oxford hip and knee scores and EQ-VAS data) showed hip and knee replacement surgery at the hospital to be within the expected range in comparison to the England average.
- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was similar to or better than the England average for all specialties except for non-elective trauma and orthopaedics.
- The orthopaedic department at the hospital planned to conduct a review of orthopaedic services that included a multidisciplinary external review of the hip fracture pathway by the British Orthopaedic Association during June 2015 to assist in identifying quality improvements in areas such as patient outcomes and rates of readmission.
- The average length of stay for elective and non-elective patients across all specialties was either similar to or better than the England average.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Records showed 71% of staff across the elective services division had completed their annual personal development reviews (appraisals) up to the end of January 2015.
- Appraisals were on-going and staff told us they routinely received supervision and annual appraisals.
- Records showed 17 out of the 18 (94.5%) eligible medical staff within surgical services who had reached their revalidation date had been revalidated with the General Medical Council. One doctor had their revalidation date deferred and this was due to take place in July 2015.
- Records up to January 2015 showed 93% of doctors across the elective services division had completed medical appraisals.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, social workers as well as diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctors.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open on Saturdays and Sundays.

- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- The hospital used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Notice boards detailed information relating to staffing levels and identified patients with specific needs, such as patients at risk of falls. Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected.
- Staff told us the information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the trust's intranet.
- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to explain how they sought informed verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- A surgical doctor told us they used the abbreviated mental test (AMTS) score to assess elderly patients and the AMTS score was also repeated after the patient underwent surgery. Patient records showed that doctors used the AMTS score to identify patients that lacked capacity.
- Staff assessed patient capacity and sought consent in accordance with legal requirements. If patients lacked the capacity to provide informed consent, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- The records for a patient on the emergency orthopaedic ward showed a best interest meeting had taken place and this included discussions by a multidisciplinary team as well the relatives of the patient.
- There was a trust-wide safeguarding lead that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.

Are surgery services caring?

Good

Patients spoke positively about their care and treatment.They were treated with dignity and compassion.

Feedback from patient satisfaction surveys showed that most patients were positive about recommending the surgical wards to friends and family. Staff kept patients and their relatives involved in their care and supported their emotional needs.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- We spoke with 11 patients. All of them said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. Patients told us the overall services and nurse staffing levels had improved over the last few years.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between December 2013 and November 2014 showed the three surgical wards consistently scored above 90%. This was better the England average and indicated that most patients were positive about recommending the surgical wards to friends and family.
- The percentage of patients that completed the survey out of all eligible patients (average response rate) ranged from 38% to 50%, which was better than the England average of 32%. Ward staff told us they routinely encouraged patients to complete the test when they were discharged from the hospital.

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Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment. Day case patients were also given a mobile tablet with a video explaining their day surgery procedure.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.

Emotional support

- Patients told us they were supported with their emotional needs. Information was available to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.

Are surgery services responsive?

Requires improvement

Surgical services failed to meet 18 week referral to treatment standards for ear, nose and throat (ENT) surgery and for trauma and orthopaedics during the past year. The plans to improve compliance included improved planning to reduce the back log of patients, improving theatre capacity and the use of external private sector and NHS healthcare organisations to treat patients awaiting surgery.

There were 550 operations cancelled between May 2014 and April 2015, including 331 operations that were cancelled on the day of surgery. The most frequent reasons for cancelled operations were hospital reasons, bed shortages and lack of theatre time. The number of patients whose operations were cancelled and were not re-booked within the 28 days was worse than the England average between October 2012 and September 2014. The number of theatre sessions that started more than 15 minutes late was approximately 83% between May 2014 and April 2015, compared to the hospital's target of no more than 10% late starts.

Theatre sessions were frequently delayed and started more than 15 minutes late due to patient management and surgeon or anaesthetist delays. Surgical services planned to improve theatre efficiency and reduce cancelled operations by implementing a centralised booking and scheduling process and had opened a surgical admissions lounge to improve patient flow.

There were systems in place to support vulnerable patients. Complaints relating to surgical services were resolved but the majority of these complaints had not been resolved within the agreed time frames. Complaints about the service were shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, oral surgery, ear, nose and throat (ENT) day surgery, plastic surgery and general surgery (such as colorectal surgery).
- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital, such as vascular surgery, maxillofacial surgery, ophthalmology and urology. The arrangements included on-call cover and support from neighbouring trusts for patients that self-presented in the emergency department.
- The hospital had 10 operating theatres for inpatient and day case surgery. There was a 24 hour service so any patients admitted during out of hours and weekends that required emergency general surgery or trauma surgery could be operated on in a timely manner.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.

Access and flow

Surgery

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patients stay at the hospital.
- The overall trust-wide bed occupancy rate between April 2013 and March 2015 ranged between 85.1% and 92%. The high level of bed occupancy was reflected in the surgical wards we visited as we found that all available beds were occupied. Bed occupancy was monitored on a daily basis and patients were transferred to other wards if no beds were available within a specific surgical specialty ward.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. Records showed that since April 2014 there had been a total of 326 instances (number of bed days) where beds in the three surgical wards were occupied by medical outliers. Staff on the surgical wards told us medical outlier patients were seen daily by medical doctors.
- Records showed that since April 2014 there had been a total of eight instances (number of bed days) where general surgical and orthopaedic patients were placed in the medical wards (surgical outliers).
- During the inspection we found two surgical outlier patients in the acute medical unit (AMU) and both patients had been seen by surgical doctors. A junior doctor told us the surgical consultants and doctors were issued with a daily list of patients across the hospital's wards and surgical outlier patients were seen daily by the surgical doctors. We also saw evidence of this in the patient records we looked at.
- Records for all operations cancelled across surgical services (including prior to admission and on day of surgery) showed there had been a total of 550 operations cancelled between May 2014 and April 2015. This included 331 operations that were cancelled on the day of surgery. The most frequent reasons for cancelled operations were hospital reasons (29%), bed shortages (22%) and lack of theatre time (12%).
- NHS England data showed that between October 2012 and September 2014 the hospital performed worse than the England average for the number of patients whose operations were cancelled and were not re-booked within the 28 days. A total of 52 patients were not re-booked within 28 days during this period.
- Records showed theatre utilisation (efficiency) ranged between 79.1% and 87.3% between May 2014 and April 2015, which was below the hospital's target of 87.5%. The data showed the number of theatre sessions that started more than 15 minutes late was approximately 83% during this period, compared to the hospital's target of no more than 10% late starts. The most frequent reasons for theatre delays between November 2014 and April 2015 were patient management (30.8%), surgeon delay (12.6%) and anaesthetist delay (9.6%).
- The surgical services had an improvement plan to reduce the number of cancelled operations and improve theatre efficiency. This included the creation of a centralised booking and scheduling team during March 2015 to improve access to surgical services. Patient booking and scheduling was previously carried out by separate speciality or directorate teams.
- A surgical admissions lounge was opened within the day surgery unit during April 2015 to improve patient flow on the day of surgery and increase day of surgery admission rates. This allowed surgical and orthopaedic patients to go directly to theatre from the admissions lounge and then to a surgical ward following recovery.
- The surgical services planned to start an improvement project during May 2015 to look for improvements in theatre productivity and efficiency. This included a planned review of theatre staffing levels, capacity and demand. It also included a review of surgeon and anaesthetic team performance against contractual obligations and job plans to address the reasons for late starts.
- NHS England data showed national targets for 18 week referral to treatment (RTT) standards for admitted patients were not achieved for all surgical specialties at the hospital between April 2013 and November 2014. The trust reported that following the implementation of

an electronic records system in 2013, the software used to monitor the 18 week pathway had been identified as not fit for purpose and as a consequence of this the trust was not able to track patients' 18 week pathway.

- The data showed the hospital achieved the waiting time target of 90% for general surgery (91%) and plastic surgery (94.9%). However, the waiting time target had not been achieved for ear, nose and throat (ENT) surgery (84.6%), oral surgery (84.4%) and for trauma and orthopaedics (79.5%) during this period.
- Trust data between January 2015 and March 2015 showed RTT standards for admitted oral surgery patients had recently improved and the hospital was achieving the waiting time target of 90%. The percentage of admitted oral surgery patients treated during this period ranged between 90.5% and 98.3%. The improvements were achieved through the internal management of patients with some independent sector support.
- There was an on-going action plan to improve performance against RTT standards for each specialty. This included key actions such as improved planning to reduce the back log of patients, improving theatre capacity and the use of external private sector and NHS healthcare organisations to treat patients awaiting surgery.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- The areas we inspected had dementia link nurses in place. Staff also used a 'forget me not' document for patients admitted to the hospital living with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Ward staff told us they applied 'reasonable adjustment' principles for patients with a learning disability and we saw specific care plans were in place to provide guidance for staff on how to care for patients with a learning disability.
- Staff could also contact a trust-wide safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The theatres had a designated paediatric recovery bay with capacity for three beds so children and adults could be appropriately segregated.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the hospital.
- The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the trust-wide complaints team, who notified individual managers when complaints were overdue.
- Information about complaints was discussed during monthly team meetings to raise staff awareness and aid future learning.
- The trust's complaint policy stated that the service would agree a timeframe with the complainant as "a means of setting a realistic timescale given all the circumstances which may arise – the trust will still aim to resolve the majority of complaints in 25 working days though for complex cases this may be 45 working days if investigation or Root Cause Analysis is required".
- Records showed between July 2014 and April 2015 there were 47 complaints relating to surgery. We found complaints raised by patients were not always resolved within the agreed timescale.

Are surgery services well-led?

Good

The trust vision and values had been cascaded across the surgical wards and departments and staff had a clear understanding of what these involved. The overall lead for the service was the divisional director of operations. As part of the ward reconfiguration plan, the trauma unit was

swapped with the surgical unit during February 2015. This allowed orthopaedic services (elective and emergency) to be carried out in adjacent wards in a single location to allow improved patient flow and increased the number of beds available for general surgery patients to 37 beds.

The wards and theatres had clear and visible leadership with clinical, nursing and business leads. The majority of staff were positive about the culture and support available. Monthly governance meetings reviewed incidents, key risks and monitoring of performance. There was routine public and staff engagement and actions were taken to improve the services.

Vision and strategy for this service

- The trust had a mission statement: 'At Tameside Hospital 'Everyone Matters'. Our aim is to deliver, with our partners, safe, effective and personal care, which you can trust'.
- This was underpinned by a set of values and behaviours that were based on safety, care, respect, communication and learning.
- The corporate objectives had been incorporated into the key priorities for surgical services. The surgical services strategy 2015/16 listed a number of key objectives based on providing safe and high quality clinical services for patients**,** to achieve financial stability**,** to enhance patient experience and quality of care and to work effectively with strategic partners.
- The trust vision, values and objectives had been cascaded to staff across the wards and theatre areas and staff had a good understanding of these.

Governance, risk management and quality measurement

- There were monthly divisional quality and governance board meetings and monthly staff meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Risks were documented and escalated by the service appropriately. The risk register for elective services listed risks relating to surgical services and this showed that key risks had been identified and assessed.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- The surgical services had clinical dashboards in place that showed performance against key performance targets including patient safety, audit compliance and staffing levels and training. These were displayed on notice boards in the areas we inspected.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to ward and theatre managers through performance dashboards.
- During our previous inspection in May 2014, the trauma unit (37 beds) and orthopaedic unit (16 beds) were located in two separate locations. The surgical unit had 24 beds and was located next to the planned elective unit. The service had identified that this had an impact on patient flow and performance.
- As part of the ward reconfiguration plan, the trauma unit was swapped with the surgical unit during February 2015. This allowed orthopaedic services (elective and emergency) to be carried out in adjacent wards in a single location to allow improved patient flow and increased the number of beds available for general surgery patients to 37 beds.

Leadership of service

- The division of surgery / women and children's was formed in February 2015, combining the previous divisions of elective services and women's and children's.
- The overall lead for the service was the divisional director of operations, who was supported by the clinical director for elective services and the interim head of nursing. The head of nursing role will be superseded by an assistant chief nurse for surgery due to commence in post in June 2015 as a substantive post holder.
- The surgical wards were led by ward managers that reported to the matron for surgery. The theatres and day case unit were led by nursing team leaders and there was an interim theatre business manager in place, with a permanent post currently advertised.

- Each surgical specialty had a lead consultant with time specified within their job plan to carry out specific duties relating to the lead role.
- The theatres and ward based staff told us they understood the reporting structures clearly and described the managers and matron as approachable, visible and who provided good support.

Culture within the service

- The staff were highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- The majority of staff we spoke with felt there had been positive changes that had led to improvements in the delivery of care since our last inspection in May 2014.
- Records showed the staff turnover rate across the elective services division was 10.7% over the last 12 months.
- Records showed staff sickness levels across the elective services division were 4.8% over the last 12 months. The sickness levels were higher than the overall trust target (3.4%) and worse than national averages during that period. The most frequent reasons for staff sickness were gastrointestinal problems, back problems, other musculoskeletal problems and other unknown causes.
- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of overtime for existing staff and bank and agency staff.

Public and staff engagement

- Staff sought feedback from patients by asking them to complete a feedback survey. The survey covered key areas such as staff courtesy, privacy and dignity, cleanliness, medication and discharge processes. The information was used to look for possible improvements to the service.
- The combined scores from all surveys submitted between November 2014 and April 2015 on the surgical wards, endoscopy unit and day surgery unit ranged from 90.7% to 92.6%, based on a total of 1003 responses. This showed the majority of patients were satisfied with the care they received.
- The surgical services had also created patient stories as part of the engagement and these were cascaded to staff via newsletters and the hospital's website to promote service improvement.
- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The surgical services had reviewed the findings from the 2014 survey of NHS staff and identified areas for improvement relating to staff appraisals, training, sickness rates and improving communication between senior management and staff.
- The NHS staff survey 2014 action plan for elective services listed actions taken to improve these areas including improving team meetings, implementing a 'back to shop floor' programme bi-monthly memo for matrons and improvements in training, appraisal and development opportunities for staff.
- Progress against the action plan was be monitored at the monthly divisional governance and quality board meetings.

Innovation, improvement and sustainability

- The surgical services planned to open a surgical assessment unit (SAU) within the surgical unit that would contain six patient trolleys and an eight recliner chair area to accommodate patients. The services planned for all GP and emergency patients to be admitted via the SAU to reduce emergency admission and streamline them to a 'hot' clinic for management. The hot clinic was scheduled to commence during July 2015 and the SAU was due to open during September 2015.
- The division of surgery / women and children's was formed in February 2015, combining the previous division of electives services and women's and children's. The divisional director of operations told us the new structure would lead to improved leadership and governance systems.
- The divisional director of operations was aware that further improvements were needed in areas such as

theatre efficiency and compliance with RTT standards but was confident about the sustainability of the surgical services and their ability to implement planned improvements.

Critical care

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

Information about the service

We visited Tameside Hospital as part of our announced inspection during 28-29 April 2015. We also carried out an out-of-hours unannounced visit on 14 May 2015.

As part of the inspection, we inspected the critical care unit, which provided care for up to six level 3 (intensive care) patients and three level 2 (high dependency) patients. The services provided care and treatment to adult patients with a range of serious life-threatening illnesses located in Tameside, Glossop and the surrounding areas.

We spoke with three patients and the relatives of three patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, the senior dietician, training lead nurse, outreach specialist nurse, the matron for critical care and the consultant lead for intensive care. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

During our previous inspection in May 2014, we rated the critical care services at this hospital as inadequate. During that inspection, we found improvements were needed in the processes for patient safety, effectiveness of treatments, responsiveness of the services and leadership and governance.

During this inspection we found the staffing levels and skills mix was sufficient to meet patients' needs. However, the on-call consultant cover was not always provided by a consultant in intensive care medicine. The service planned to address this by creating a separate on-call rota to provide cover specifically for the critical care services. The majority of staff had completed their mandatory training but the hospital's target of 95% compliance had not been fully achieved. Patient safety was monitored and incidents were investigated and shared with staff to assist learning and improve care. Patients received care in clean and suitably maintained premises.

The critical care services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed similar to the England average for all performance measures in the Intensive Care National Audit and Research Centre (ICNARC) 2013/14 audit. This meant the majority of patients had a positive outcome following their care and treatment. However, the target to admit 95% of patients within four hours of referral was not

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achieved. During April 2014 and March 2015 a total of 46 patients had been discharged during out-of-hours, compared to the hospital's target of zero out-of-hours patient discharges.

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. However, complaints raised by patients were not always resolved within the agreed timescales.

Patients received care and treatment by multidisciplinary staff that worked well as a team. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards. Patients and relatives spoke positively about their care and treatment. Staff kept patients or their relatives involved in their care and supported them with their emotional and spiritual needs. There was effective teamwork and clearly visible leadership within the critical care services. Staff were positive about their work and enthusiastic about the improvements and changes taking place.

Are critical care services safe?

Good

Patient safety was monitored and incidents were investigated and shared with staff to assist learning and improve care. Patients received care in visibly clean and suitably maintained premises. Patients were supported with the right equipment and staff adhered to infection prevention and control policies and protocols. Patient records were completed appropriately.

The staffing levels and skills mix was sufficient to meet patients' needs. However, the on-call consultant cover was not always provided by a consultant in intensive care medicine. The service planned to address this by creating a separate on-call rota to provide cover specifically for the critical care. The majority of staff (75.9%) had completed their mandatory training but the hospital's internal target of 95% compliance in mandatory training had not been fully achieved.

Incidents

- National Reporting Learning System (NRLS) data showed there were no serious patient safety incidents reported by the critical care services between February 2014 and January 2015.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Staff told us they were encouraged to report incidents and received direct feedback from the matron for critical care.
- Incidents logged on the system were reviewed and investigated by the matron to identify learning and prevent reoccurrence.
- Staff told us incidents and complaints were discussed during monthly staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at.
- The incident reporting system provided prompts for staff to apply duty of candour (being open and honest with patients when things go wrong) for incidents that had led to serious or moderate harm.

- Patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at monthly governance meetings and hospital-wide monthly mortality steering group meetings.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- The critical care services had low levels of infections and pressure ulcers. Safety Thermometer information between December 2013 and December 2014 showed there were three pressure ulcers and three catheter urinary tract infections reported by the hospital relating to critical care services.
- Information relating to the safety thermometer outcomes was clearly displayed on notice boards within the critical care unit.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and two Clostridium difficile (C. diff) infections relating to surgery at the hospital between April 2014 and March 2015. These incidents were reported in September 2014 and November 2014.
- We looked at the investigation report and action plan for the C. diff incident from September 2014. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team. The investigation highlighted poor hand washing practice by some staff. The remedial actions included awareness and increased monitoring of staff hand hygiene practice.
- Intensive Care National Audit and Research Centre (ICNARC) 2013/14 data also showed that unit acquired MRSA and blood infection rates were similar to the England average.
- Staff demonstrated adherence and good awareness of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were hand wash sinks and hand gels available throughout the service. Staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Hand hygiene and 'bare below the elbow' audit results showed compliance by staff was 100% for most of the period between April 2014 and March 2015.
- During our previous inspection in May 2014, we identified concerns relating to the cleanliness of the environment and equipment in the pacing room (used for pacing a patient's heart during a medical emergency). During this current inspection we found the pacing room had been relocated to the theatres department and the room within critical care was no longer used for clinical activities.
- There was one side room that could be used to isolate patients identified with an infection. However, this room did not have appropriate ventilation (negative or positive air flow) which meant it could not be used for patients with certain infections.
- The critical care services had identified there were insufficient isolation facilities. As part of the reconfiguration plan, an additional isolation room was planned in the high dependency unit (HDU) so patients could be appropriately isolated if needed. The new HDU was due to open June 2015. In the meantime, there were measures in place to manage the needs of patients requiring isolation.

Environment and equipment

- The environment and equipment in critical care services were visibly clean and well maintained. Equipment was serviced by the unit technician and the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- The equipment we saw within the critical care unit included labels showing they had been serviced and when they were next due for servicing.
- Staff told us that all items of equipment were readily available and bed spaces were equipped with the right equipment needed to treat patients, such as ventilators and intubation equipment (for placement of tube in patient's airways).
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

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Medicines

- Medicines, including controlled drugs, were securely stored. Staff also carried out daily checks on controlled drugs and medication stocks.
- Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication charts for five patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- We looked at the records for two patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for venous thromboembolism (VTE)**,** pressure care or nutrition and these were completed correctly.
- The records showed timely assessments by nurses and daily consultant reviews took place.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 81.8% of critical care staff had completed safeguarding adults training and 77.3% had completed safeguarding children training
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was clearly displayed in the ITU. The unit also had a safeguarding link nurse in place.
- Safeguarding incidents were reviewed by the matron and also by the hospital's internal safeguarding board, which held meetings every two months.

Mandatory training

- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. We saw that information on mandatory training performance was displayed on notice boards in the ITU.
- The overall mandatory training completion rate for staff in the critical care unit was75.9%, which showed the majority of staff had completed their mandatory training. However, the hospital's internal target of 95% compliance in mandatory training had only been achieved for resuscitation and equality and diversity training.
- The overall completion rate for topics such as information governance, manual handling, fire safety, infection control and safeguarding training across the critical care service ranged between 36% and 95.9%.

Assessing and responding to patient risk

- Ward staff across the hospital used early warning scores. If a patient's health deteriorated, staff were supported with medical input and could access the critical care outreach team.
- Records for March 2015 showed the critical care outreach team had carried out a total of 122 patient assessments. The majority of patient assessments took place in the acute medical unit (22.1%) and the surgical unit (21.3%) and most patients (72.8%) were assessed as 'current therapy adequate'.
- Records for March 2015 showed a total of 65 patients triggered on the early warning score system across the hospital's wards and 64 of these patients (98%) were responded to appropriately with timely medical support. One patient had a delayed medical review but nursing observations had been maintained.
- Critical care staff carried out routine monitoring based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.

Nursing staffing

- Nursing staff handovers occurred twice a day and included discussions around patient needs and any staffing or capacity issues.
- During our inspection critical care services had a sufficient number of trained nursing and support staff with an appropriate skills mix on shift to ensure that patients received the right level of care.
- The unit provided care for up to six level 3 (intensive care) patients and three level 2 (high dependency) patients. All level 1 patients were nursed 1:1 and all level two patients 1:2 in accordance with Intensive Care Society (ICS) guidelines.

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- The expected and actual staffing levels were displayed on a notice board in the unit and these were updated on a daily basis.
- The staffing establishment was for nine trained nurses and a nursing assistant on each shift. There was also a lead nurse on each shift that was supernumerary and did not form part of the staffing establishment.
- There were four whole time equivalent band 6 nurse vacancies and 3.4 whole time equivalent band 5 nurse vacancies in the unit. Recruitment for additional nursing staff was on-going and there were five registered nurses in the recruitment process with agreed start dates.
- The matron for critical care told us they did not routinely use external agency or locum staff. The majority of cover for staff leave or sickness was provided by the existing nursing team. External agency staff use did not exceed 20% on any one shift and so was within levels recommended by ICS guidelines.
- The critical care outreach team included 2.8 whole time equivalent band 7 nurses that were supported by band 6 nurse secondment from critical care and a critical care doctor.

Medical staffing

- During our inspection we found, critical care services had a sufficient number of medical staff with an appropriate skills mix to ensure that patients received the right level of care. The service used minimum agency or locum medical staff and cover was arranged from the existing team.
- There was a designated lead consultant for intensive care as set out in the ICS standards.
- There were six critical care consultants committed to the unit that worked weekdays between 8am and 6pm. There was at least one consultant on the unit on weekends between 8am and 4pm.
- There were three whole time equivalent consultant vacancies and candidates for these had been identified and were currently in the recruitment stage.
- The consultant to patient ratio did not exceed 1:8 during weekdays and 1:15 during out-of-hours service in line with ICS standards.
- During the night and at weekends the ITU was covered by two middle grade doctors and a specialist trainee with sole responsibility for the ITU. They were supported by an on-call consultant that also provided cover for emergency resuscitation and maternity services as well as for critical care.
- The existing on-call consultant rota included a combination of critical care specialist and surgical consultant anaesthetists. This meant a consultant in intensive care medicine was not available 24 hours a day, seven days a week, to attend a patient within 30 minutes as set out in the ICS standards.
- The hospital planned to address this by splitting the rota so on-call cover for the critical care services was provided by specialist consultants only by August 2015.
- Medical staff handovers occurred twice a day and included discussions around patient needs. Handovers between consultants were documented on standardised summary handover sheets. The middle grade doctors also used the same standardised records to document their handover.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the critical care services, and this listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident.

Are critical care services effective?

Good

Critical care services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.

The service performed similar to the England average for all performance measures in the Intensive Care National Audit and Research Centre (ICNARC) 2013/14 audit. This meant the majority of patients had a positive outcome following their care and treatment.

Patients received care and treatment by multidisciplinary staff that worked well as a team. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society

(ICS), National Institute for Health and Care Excellence (NICE), National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations as well as guidance published by the relevant medical bodies such as the Royal Colleges and British Medical Association.

- During 2014/15 the critical care services identified six internal and national clinical audits. The services participated in two of the four national audits for which the hospital was eligible for (ICNARC and NCEPOD sepsis study). The remaining two national audits were planned but had not yet commenced and these related to NHS advancing quality (AQ) audits for sepsis and acute kidney injury. An internal audit relating to the quality and safety of handover in ITU was also planned but had not yet been completed.
- Findings from clinical audits were reviewed for any changes to guidance and the impact that it would have on practice was discussed during monthly departmental audit meetings and reviewed at monthly quality and governance board meetings.
- The critical care services carried out collaborative work with the Greater Manchester Critical Care Network. There was participation in quality audits, such as the ventilator care bundle audits. This information was shared with the care network to look for improvements to the service.

Pain relief

- The ITU had guidance available about the medicines used for analgesia. Medical staff confirmed that analgesia was a routine part of sedation management. Pain was assessed as part of the overall patient assessment and was accompanied by sedation scoring where relevant.
- There was a dedicated pain team within the hospital and staff knew how to contact them for advice and treatment when required.
- Patient records showed that patients that required pain relief were treated in a way that met their needs and reduced discomfort.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements.
- Where patients were identified as 'at risk', there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients had a poor uptake of food, this was addressed by the medical staff to ensure patient safety. The nursing assistant also assisted people who were able to eat their meals orally.
- There was a designated lead dietician for the critical care service. A dietician provided routine input from Monday to Friday and took part in ward rounds. There were protocols for initiating appropriate nutritional support out of hours.

Patient outcomes

- ICNARC data showed that trust performance was within expected levels for all measures within the audit including hospital mortality, out-of-hours discharges, non-clinical transfers out and for unplanned readmissions within 48 hours.
- Staff carried out an assessment of delirium (acute confusion) in patients using the confusion assessment method for the intensive care unit (CAM-ICU).
- Records showed at least 90% of patients were screened within 72 hours of admission or had a clinical diagnosis of delirium on initial assessment across the hospital between June 2014 and March 2015. The records showed that all patients that were identified with delirium or dementia symptoms had been assessed or referred for follow up during this period.

Competent staff

- The critical care service had a practice educator that oversaw training processes and carried out competency assessments.
- Newly appointed staff had an induction and their competency was assessed over a period of six months before working unsupervised. This was followed by additional training during the first year until staff were placed on a post graduate critical care course. Agency staff also had a competency based induction before starting work.
- Staff told us they routinely received supervision and annual appraisals. The hospital launched a revised appraisal process in April 2015 and suspended the previous process in December 2014, so current staff appraisal rates for the critical care service was not available at the time of our inspection. However, records showed 71% of staff across the elective services division had completed their annual personal development reviews up to the end of January 2015.

Critical care

- The matron for critical care told us approximately 60% of staff had completed the Post registration award in critical care nursing, which met the ICS standard for at least 50% of staff to have completed the training. The matron confirmed training was on-going and three additional nurses had been enrolled for this training during the current year.
- Records showed 100% of all eligible medical staff in the critical care services that had reached their revalidation date had been revalidated with the General Medical Council.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the critical care services. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- There was a daily ward round which had input from nursing, microbiology, pharmacy and physiotherapy.
- The nursing staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- Staff told us they received good support from pharmacists, dieticians and physiotherapists as well as diagnostic support such as for x-rays and scans. Speech and language therapists were available by referral when needed.
- The critical care outreach team provided cover for the wards and theatre recovery areas across the hospital over seven days between 7.15am and 8.15pm. Outside of these hours the night nurse practitioners received handover from the outreach team. Staff spoke positively about the support they received from the outreach team.
- From May 2015, the hospital planned to implement follow up clinics for patients that had a long term stay in ITU. The follow up clinics will be led by the ITU advanced nurse practitioner (ANP) and supported with physiotherapy and dietician support. The hospital was in the process of recruiting staff for the ANP role.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients' needs.
- Patients admitted to the ITU were seen daily by a consultant.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open on Saturdays and Sundays.
- Staff told us they received good support outside normal working hours and at weekends.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to seek consent from patients and understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff assessed patient capacity and sought consent in accordance with legal requirements. If patients lacked the capacity to provide informed consent, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- There was a trust-wide safeguarding lead that provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

Are critical care services caring?

Good

Patients or their relatives spoke positively about their care and treatment.They were treated with dignity, empathy and compassion.

Staff ensured patients or their relatives were involved in their care and supported them with their emotional and spiritual needs.

Compassionate care

Critical care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. The patients we saw were well positioned and their dignity was maintained.
- We spoke with three patients and the relatives of another three patients. All the patients and relatives said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- Patients and relatives spoke positively about staff attitude. One patient commented that: "Sometimes they are very busy but they are very good if I need anything".
- We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to a side room to provide privacy and to respect their dignity.

Understanding and involvement of patients and those close to them

- Patients and relatives spoke positively about the support received from staff. Patient relatives told us they had been kept fully updated and had had opportunities to have all their questions answered.
- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible the views and preferences of patients were taken into account and this was documented in their records. Relatives of patients told us staff had asked them about patient preferences and likes and dislikes.
- Patients told us they were seen daily by a consultant or doctor and the medical staff had clearly explained their care and treatment to them.
- Staff told us they planned to introduce 'memory books' to assist the recovery of confused or unconscious patients during their stay.

Emotional support

- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- Staff could seek support from the palliative care team if a patient required end of life care. Staff were also able to provide overnight accommodation for relatives of patients.
- Patients and relatives told us they were satisfied with the communication and level of support they received. One patient described how she had been having strange dreams and thoughts and the staff had taken the time to talk with her and offer their support.
- Staff provided relatives of patients with bereavement leaflets that provided information. There was a bereavement service in place to support patients, relatives or staff.
- Information about chaplaincy services and spiritual support was displayed on notice boards in the unit.

Are critical care services responsive?

Requires improvement

NHS England data showed overall bed occupancy levels varied between May 2013 and November 2014 with levels peaking above the average in December 2013 and January, April, May, June and October 2014. The rest of the time levels were around the England average of 81.4%. The number of patients that were admitted within four hours of referral ranged between 29.4% and 78.6% between April 2014 and March 2015. This meant the trust's target to admit 95% of patients within four hours of referral had not been achieved. During this period, a total of 46 patients had been discharged during out-of-hours. The hospital's target was for zero out-of-hours patient discharges.

The service reconfiguration aimed to improve capacity during June 2015 by separating the intensive care and high dependency into two separate units, with each unit having six allocated beds. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There had only been three complaints relating to critical care services between July 2014 and April 2015 but these were not responded to within the agreed timescales.

Service planning and delivery to meet the needs of local people

- The unit provided critical care services for adults over the age of 16 years. The service did not admit children

below 16 years of age, patients with infectious diseases requiring a high level of isolation and patients requiring neurological therapeutic monitoring and treatment. If these patients presented at the hospital, they would be assessed by the critical care staff and then would be transferred to other hospitals in the local area.
- As part of the reconfiguration plan, the coronary care unit (CCU) had been relocated to the cardiology ward and was no longer part of the critical care service.
- The hospital planned to separate the intensive care and high dependency into two separate units, with each unit having six allocated beds. The high dependency unit was being refurbished at the time of our inspection and was due to open in June 2015. The unit included an isolation room and improved bathroom facilities for high dependency patients.
- A staffing review carried out during April 2015 highlighted the planned move to the two units required an additional 16.3 whole time equivalent nurses. As part of on-going staff consultations, eight nurses that had previously worked in the coronary care / high dependency unit had agreed to transfer to the unit and they were scheduled to start in July 2015. Recruitment to fill the remaining vacancies was on-going and any staffing shortfalls were expected to be addressed with the use of agency staff.

Meeting people's individual needs

- Information leaflets about the services were readily available. We did not see written information readily available in different languages or other formats, such as braille. However, staff told us these could be provided upon request.
- Staff could access a language interpreter if needed.
- Staff could also contact the trust-wide lead for advice and support when caring for patients living with dementia or a learning disability.
- Staff involved carers and others involved in the patient's care and specific care plans were put into place.
- There were defined visiting hours for relatives. However, relatives could arrange to visit patients at any time during the day depending on the patient's condition.
- Staff could access appropriate equipment to support the moving and handling of bariatric patients (patients with obesity) admitted to the critical care unit.

Access and flow

- Staff carried out daily meetings to maintain patient flow and to identify and resolve any issues relating to the admission or discharge of patients.
- NHS England data showed overall bed occupancy levels varied between May 2013 and November 2014 with levels peaking above the average in December 2013 and January, April, May, June and October 2014. The rest of the time levels were around the England average of 81.4%. During the inspection, we saw that all available beds were occupied.
- Records between May 2014 and March 2015 showed there were eight instances where elective surgery procedures or urgent surgery was cancelled due to a lack of clinical care beds. The low level of cancellations was partially due to the small numbers of patients requiring a high dependency bed post-operatively and also due to the pre-operative screening process.
- The critical care unit operated a closed admission policy with all admissions needing to be discussed between the referring team and the critical care consultant. Unplanned admissions to the unit required consultant to consultant referral prior to admission.
- ICNARC data showed the number of patients transferred out for non-clinical reasons was within expected levels but was worse than the England average. The number of out-of-hours discharges to the ward and unplanned readmissions within 48 hours was within expected levels and was about the same as the England average. The number of delayed discharges (both 12 hour delay and 24 hour delay) was also within expected levels when compared to other hospitals but was better than the England average.
- The number of patients that were admitted within four hours of referral ranged between 29.4% and 78.6% between April 2014 and March 2015. This did not meet the hospital's target of 95% and showed a number of patients were not admitted to the unit within the required four hour timeline. Minimising delays to treatment is associated with better outcomes.
- Records between April 2014 and March 2015 showed a total of 46 patients had been discharged during out-of-hours. The hospital's target was for zero out-of-hours patient discharges. ICS guidelines state that discharges overnight have been historically associated with an excess mortality and can be an unpleasant experience for patients.
- The hospital planned to improve patient flow across the hospital's other departments that would lead to

improvements to admission and out-of-hour discharge performance within critical care. An audit was currently taking place to check that time to admit was being recorded to allow the service to measure the four hour admission performance indicator more accurately.

Learning from complaints and concerns

- Information on how to raise complaints was displayed within the critical care services and included contact details for the Patient Advice and Liaison Service (PALS).
- The matron for critical care was responsible for reviewing and investigating complaints. Information about complaints was discussed during monthly team meetings to raise staff awareness and aid future learning.
- The trust's complaint policy stated that the service would agree a timeframe with the complainant as "a means of setting a realistic timescale given all the circumstances which may arise – the trust will still aim to resolve the majority of complaints in 25 working days though for complex cases this may be 45 working days if investigation or Root Cause Analysis is required".
- Records showed there were only three complaints relating to critical care services between July 2014 and April 2015. However, all these were not responded to within the agreed timescales.

Are critical care services well-led?

Good

The trust vision, values and objectives had been cascaded to staff across the critical care unit and staff had a good understanding of these. There was effective teamwork and clearly visible leadership within the critical care services. Staff were positive about their work and enthusiastic about the improvements and changes taking place.

There were monthly division quality and governance meetings and monthly staff meetings. Key risks had been identified and assessed. These were reviewed during the monthly governance meetings. Identified performance shortfalls were addressed by action planning and regular review.

There had been a number of improvements made since our last inspection, such as improvements made in ICNARC audit participation and performance. As part of the reconfiguration plan, the services planned to increase capacity from nine beds to six intensive care beds and six high dependency beds.

Vision and strategy for this service

- The trust had a mission statement; "At Tameside Hospital 'Everyone Matters'. Our aim is to deliver, with our partners, safe, effective and personal care, which you can trust."
- This was underpinned by a set of values and behaviours that were based on safety, care, respect, communication and learning.
- The trust's vision and values were embedded within the critical care service and fed into the reconfiguration of the service. However, at the time of our inspection there was no specific strategy for critical care services. The matron's key priorities for the service had been to address the issues identified during our last inspection.
- The trust vision, values and objectives had been cascaded to staff across the critical care unit and staff had a good understanding of these.

Governance, risk management and quality measurement

- There were monthly division quality and governance meetings and monthly staff meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Within the critical care unit, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Risks were documented and escalated by the service appropriately. The risk register for elective services listed risks relating to surgical services and this showed that key risks had been identified and assessed and action plans were in place to address these.
- We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards.

Leadership of service

Critical care

- The critical care services were incorporated into the elective services division during April 2014.
- There were clearly defined and visible leadership roles within the critical care services. There was a designated lead consultant for intensive care that oversaw the critical care services. The nursing staff were managed by a supernumerary lead nurse on each shift, who reported to the matron for critical care services.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were highly motivated and positive about their work. All the staff we spoke with were enthusiastic about the changes and improvements that had taken place.
- The matron for critical care services had been in post since January 2015. Staff told us they received a good level of support from their peers and from the matron. A nurse commented that "your voice is heard, there is an open culture with the new leadership team".
- Records showed staff sickness levels across the critical services over the last 12 months were 5.14%, of which 2.66% were for staff on long-term sick leave.
- The sickness levels were higher than the overall trust target (3.4%) and worse than national averages during that period.

Public and staff engagement

- The critical care services did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment.
- Staff sought feedback from patients and their relatives by asking them to complete a feedback survey. The survey covered key areas such as staff courtesy, privacy and dignity, cleanliness, medication and discharge processes. The information was used to look for possible improvements to the services.
- Records showed that between November 2014 and April 2015, 12 feedback surveys had been submitted and the overall satisfaction score was 91.06%.
- The patients and relatives we spoke with were complimentary towards the staff and about the level of involvement and support provided.
- The critical care services had also created patient stories as part of the engagement and these were cascaded to staff via newsletters and the hospital's website to promote service improvement.
- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings. The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards.
- The critical care services had reviewed the findings from the 2014 survey of NHS staff and identified areas for improvement relating to staff appraisals, training, sickness rates and improving communication between senior management and staff.
- The NHS staff survey 2014 action plan for elective services listed actions taken to address areas for improvement identified in the 2014 survey of NHS. These included improving team meetings, implementing a 'back to shop floor' programme, bi-monthly memo for matrons and improvements in training, appraisal and development opportunities for staff.

Innovation, improvement and sustainability

- The critical care services carried out collaborative work with the Greater Manchester Critical Care Network. There was participation in quality audits, such as the ventilator care bundle audits. This information was shared with the care network to look for improvements to the service.
- There had been a number of improvements made since our last inspection, such as improvements made in ICNARC audit participation and performance. As part of the reconfiguration plan, the services planned to increase capacity from nine beds to six intensive care beds and six high dependency beds.
- The matron for critical care was confident about the ability of the service to meet patient needs in the future. The key risks to the critical care services were to ensure sufficient nursing and medical staffing for seven day services and their ability to admit and discharge patients in a timely manner.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at Tameside Hospital Trust reported 329,765 total appointments in the 12 months from July 2013 to June 2014. Most clinics are held in the main area situated at the Hartshead South Entrance. The facilities include a café, shop, large waiting areas, an information service, staffed reception areas and automatic check in points. There is also a separate children's outpatient clinic situated in this area.

The diagnostic imaging department consists of a waiting area, patients' changing cubicles, and rooms with equipment to provide plain film x-rays, ultrasound scans, cardio echography scans, magnetic resonance imaging and various other specific diagnostic procedures. The department is situated on the ground floor close to the emergency department, with portable equipment available for use on the wards and other areas.

During this inspection we visited11 clinics, three diagnostic areas, spoke with 37 patients and their relatives, 20 staff members of various grades, nine administration staff and senior staff responsible for service improvement in the outpatients departments. We observed interactions between patients and staff, reviewed records relating to patient care and the management of the service. We reviewed information provided by the trust both before and during the inspection.

Summary of findings

There had been improvements in the outpatients department since the last inspection. These included increased nursing staffing resulting in more clinics being available and additional out of hours clinics. There had been changes to the administration systems with additional roles and staff numbers which had resulted in better management of the waiting lists and improved communication with patients. The waiting times for an appointment from referral were better than the England average and plans were in place to improve this further. Policies and procedures were in line with recognised guidance and were up to date. There was effective multi-disciplinary working between local hospitals and between clinical specialists within the hospital.

Staff treated patients with respect, patience and kindness. They protected their privacy and dignity and provided support to them in a sensitive and discreet manner. Concerns were raised at the inspection on 29 April 2015 about some aspects of the resuscitation equipment and training. Changes to address these concerns had taken place at the unannounced inspection on 14 May 2015 with plans to make further improvements.

Despite a large number of improvements made in the past six months there was no formal audit programme in place to monitor the effectiveness of these changes. There had been changes in the leadership in the outpatient department and staff were positive about the improvements they had made. They felt increasingly

able to contribute to the planning and delivery of the service, were included in joint working and described an increased team approach. However some staff in the diagnostic imaging service did not feel included in the changes that had been made or that they had led to positive outcomes for patients.

Are outpatient and diagnostic imaging services safe?

Requires improvement

There were systems in place to learn from incidents and recent training for staff had helped their understanding of this mechanism; however, there was no regular written update for outpatient staff regarding learning from incidents and complaints. Areas were visibly clean and tidy. Medicines were stored and recorded in accordance with current guidance. However, the disposal of controlled drugs was not in line with current guidance. The pharmacy team confirmed that a new procedure was being introduced to address the issue. Since the last inspection the handling and storage of patient's records had been improved and the processes in place were safe and effective. Not all staff were following good hand hygiene practices, nor were they encouraging patients and visitors to use follow these practices. Hand gel was available, but we did not always see it used.

During the announced inspection we identified concerns that in some clinics, staff had not seen inside some of the boxes on the emergency equipment trolleys (particularly for paediatric patients) and no drills with this equipment had taken place. We raised this with the trust at the time of our inspection ad by the time of our unannounced inspection the trust had taken appropriate action to address our concerns. Storage of fluids for emergency use had also been made secure.

Staff in all roles were aware of their responsibilities to protect children and vulnerable adults. Most of the mandatory training was up to date although there was reduced compliance with moving and handling training. A plan was in place to improve this. The numbers of nursing staff had increased since the last inspection and there were no vacancies. There had been changes to the administration systems with additional roles and increased staff which had resulted in better management of the waiting lists and improved communication with patients.

Incidents

Outpatients and diagnostic imaging

- Staff told us they were actively encouraged to report incidents and the system was easy to use. They were aware of additions to the incident report system, such as delays in start times of clinics, and their responsibility to report these.
- Managers told us there had been an increase in staff reporting incidents as they had received training about what constituted an incident and had more confidence that they would not be "in trouble" for reporting any incidents.
- Monthly meetings for the senior nursing staff were held and clinical incidents were discussed. Any necessary changes as a result of incidents were actioned and staff were informed by their line manager.
- There was no regular written update for outpatient staff regarding learning from incidents and complaints; however a bulletin had been used in the past to pass learning to staff in the clinics.
- The diagnostic imaging manager said they had set up a monthly quality meeting which any staff member could attend. This was designed to provide a forum for staff to look at images which had been taken and learn from incidents which may have arisen, such as misdiagnosis.
- In the radiology department there had been a change in procedure following three incidents relating to incorrect identification of the patient. The identification process had increased from three to seven points of information including laterality (which side) and previous images.
- Senior staff had received guidance about the duty of candour regulations and their responsibilities under this legislation.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy.
- The cleaning staff said a supervisor checked the areas they cleaned each evening after they had completed their work.
- In some areas the environment was showing signs of wear and tear such as the work surfaces and sinks in the orthodontic clinic. This had been included on the risk register and plans for replacement were in place.
- 85.9% of nursing staff had completed infection prevention and control training. Those we spoke with from various roles understood their responsibilities to prevent the spread of infection.
- During our visit we saw a lack of staff using the hand hygiene gel and reminding visitors to the various outpatient areas to do the same. Hand hygiene was audited and the score the previous month was 100%. One senior staff member said hand washing spot checks were carried out and staff were reminded of the importance of hand hygiene frequently. There were a lot of hand gel pumps available and we were told some had been added as patients had said they could not observe staff using them. This lack of staff visibly using the hand gel could increase the risk of cross infection and reduce the confidence of patients in infection control measures.
- Curtains around the treatment cubicles in the phlebotomy department were clean and had signs on indicating when they were due to be changed. This was an improvement since our last inspection.

Environment and equipment

- We saw and staff confirmed there was a variation in the resuscitation equipment provided in the different clinic areas. There were some specifically designed trolleys and others were open equipment trolleys with unlabelled boxes of medical devices. Emergency medicines were provided in secure boxes. Not all staff we spoke with were familiar with the equipment (particularly paediatric equipment) nearest to their area which meant in an emergency they may not be familiar enough with it to provide timely assistance.
- Senior staff, in some clinics, confirmed they had not seen inside some of the various boxes on the emergency equipment trolleys, such as that for use with children. They said no drills with this equipment took place. This meant staff had not received training with the equipment they may need to use in an emergency. At the unannounced inspection some staff had received training using this equipment and further training was planned to include all nursing staff.
- There were recorded checks of the emergency equipment in all areas; however due to some staff not being aware of the contents of all the various boxes these checks may have been insufficient.
- We saw and staff told us that emergency repairs to clinic areas were carried out quickly.
- Most of the portable electrical equipment we saw was up to date with maintenance checks; however not all of it was such as a fan in the orthodontic clinic which was six months out of date. Staff told us the checking of this equipment was the responsibility of the estates department and they did not check that such equipment was up to date with safety checks.

- Additional equipment to assist with the correct moving and handling of records had been introduced. This included equipment to safely reach records stored high on shelving, increased shelving and additional trolleys.

Medicines

- Medicines were correctly stored and appropriate records were maintained.
- We requested specific data in relation to the outpatients department but no information about the numbers of staff who had completed training in the safe management of medicine was provided. Staff said (and managers confirmed) they completed this training once in their employment and there were no competence assessments in place. This meant the management of medicines by staff was not monitored for compliance.
- Where intravenous fluids were required as part of the emergency equipment they were not in locked storage, which pharmacy told us was against their guidance. Where this equipment was in areas which may be accessible to patients without staff being present, there could be a risk of intentional contamination. We raised this concern with the pharmacy. At the time of the unannounced inspection these fluids had been removed and were stored in a locked cupboard. There were plans to add locks to the emergency trolleys and then the fluids would be replaced.
- Fridge temperatures were checked and recorded.
- The disposal of controlled drugs did not meet with recommended guidance. Two staff members told us they would dispose of wasted liquid controlled drugs down the sink or in the open glass container into a sharps box. They were aware and pharmacy confirmed that a new procedure was being introduced which met with current guidance.
- Blank prescriptions for use by medical staff in the clinics were securely stored and provided to prescribing staff at the beginning of each clinic. There was no record kept of the usage of prescriptions which meant the safe use of these records was not monitored.
- Where controlled drugs were required we saw these were stored securely with accurate records kept.
- In areas where sedation was required, piped oxygen was available. Other piped gases could be made available if necessary.
- No medicine management audits were completed. This meant there were no checks in place to ensure staff were correctly following the trust's policies.

Records

- We found, the building where records were stored had been tidied thoroughly since our last inspection; records were on shelving, corridors and doorways were clear.
- A new system had been introduced for the electronic tracking of records which meant a bar code system and a hand held device could be used to locate any records required.
- At the last inspection we found some records were very bulky and presented a moving and handling hazard. At this inspection there were no records which were large or heavy and staff said a new system of archiving had been introduced to reduce this risk.
- Patients' medical records were securely stored and confidentiality was protected in the clinic areas. Locked cabinets and trolleys were in use.
- The records we looked at contained the relevant patient identification information, assessments and treatment plans. According to data provided by the trust, only 0.2% of patients were seen in outpatients without the full medical record being available.

Safeguarding

- Medical, nursing, administrative and diagnostic staff understood their role and responsibilities with regard to safeguarding vulnerable adults and children in their care. They told us there was good support from the hospital safeguarding team and they knew how and when to report any concerns to the local authority.
- 95.3% of staff were up to date with training in the safeguarding of vulnerable adults. 93.8% had completed training in safeguarding vulnerable children. This meant the majority of staff had been given the information they required to protect vulnerable adults and children from abuse.
- Nursing and medical staff, except those in the breast care clinic, were unclear about the trusts' chaperone policy and if a chaperone should be formally offered. They told us patients could ask for one if they wished. The policy stated "All patients should be routinely offered a chaperone during any consultation or procedure." It goes on to state this should be "made clear to the patient prior to any procedure, ideally at the time of booking the appointment". Patients we spoke

with had not been offered a chaperone, but thought they could have someone with them if they wished. This meant the trusts' policy to offer a chaperone was not being followed.

Mandatory training

- Mandatory training was a mixture of e-learning and some face to face training such as moving and handling. The compliance with the mandatory training for staff in the outpatient department was 87.5%.
- We were told by staff in several areas that there had been a delay in accessing moving and handling training due to the lack of trainer. Nursing staff were now being updated with this training and 93.8% had completed the theory and 73% the practical. In the radiology/ radiography services 55.1% of staff were up to date with this training. They told us they did carry out a significant amount of moving and handling of patients to position them on the various equipment and therefore nearly half of the staff were doing this without the necessary knowledge and skills.
- Training to increase the knowledge and skills of staff working in specific clinics was underway. This included training for the cardiology clinic nurses, some of which was delivered by consultants, in recognising various heart arrhythmias, updates on echo cardiogram procedures and hypertension updates.
- Role specific training was provided for staff in the outpatient department such as study days for pre-operative assessment.
- Nursing staff said should a specialist course be beneficial to patient care they were supported to access this. One nurse had completed the National Breast Care Nursing Course to help improve the care in the clinic and cascade their knowledge to other staff.

Assessing and responding to patient risk

- Nursing, administration and diagnostic staff could describe the procedures they would follow to summon emergency medical assistance if a patient became acutely unwell. This included knowing where emergency call bells were situated and if they were responsible to attend certain areas, such as the cardiology team who were part of the emergency response.
- Staff in the phlebotomy department discussed how they would assist patients who may become unwell during procedures. This included not leaving them alone and knowing where to get medical assistance from if it was required.
- Procedures were in place where potential adverse reactions to substances such as contrast medium were used. These included emergency medicines and staff knew how to summon medical assistance and understood their part in emergency procedures.
- 78% of nursing staff had completed training in the resuscitation of adults. This meant not all staff were up to date with this emergency treatment for patients.
- A manager said nursing staff in the general outpatient department were not trained in paediatric resuscitation. Although there was a specific paediatric outpatient department the general department was used for children's clinics such as dental treatment. This meant staff had not completed training to provide emergency resuscitation for children despite them being treated in the area. At the unannounced inspection, training of the staff in the adult areas had begun and there was a plan to include all nursing staff in this training.
- It was recognised that the high number of non-medic referrals to radiology was increasing the risk of exposure to x radiation for patients if the tests were not necessary. Measures had been put in place to reduce this risk which included training and competence assessments for all non-medical staff who may refer and a changed procedure for authorisation by non –medical staff.

Nursing staffing

- There had been an increase in in the past six months of nursing staff of all grades working in the outpatient department resulting in no current vacancies. Some reconfiguration from inpatient departments had taken place along with recruitment of new staff. This meant there was no reliance on agency or bank staff which increased the continuity of staffing within the department.
- There were three vacancies for health care assistants which were advertised. Whilst these posts were vacant agency staff were used to maintain adequate staff numbers.
- At the last inspection nursing staff told us they were often moved around between clinics which led to them not having an adequate knowledge of the preparation

required or specifics of the clinical specialism. Staff told us this was now resolved and they worked in teams in specific clinics. This meant they were more skilled when working in their specific area.

- An electronic duty rostering system was used which aided senior staff members to maintain sufficient nursing staff on duty in each clinic. Staff said and we saw that there were usually enough staff on duty.
- We were told the recent improvements in the leadership of the trust and increased staff engagement had reduced the short term sickness levels. Information provided by the trust showed for nursing staff it had reduced from 3.29% in April 2014 to 1.9% in March 2015. However long term sickness had increased since September 2014 from 1.47% to 7.25% in March 2015. We were given examples of how managers were addressing this sickness rate with initiatives to help staff return to work.
- There was some use of agency staff for specific areas such as plaster room technicians in the fracture clinic. These posts were advertised and recruitment was underway.
- Nurses in the paediatric outpatient department included those trained in children's nursing. There were additional staff to assist in the support of children and families such as the play therapist.
- Clinical nurse specialists were employed by some clinical teams and supported medical staff in the outpatient clinics. This included rheumatology, colorectal and epilepsy clinical specialists which meant patients could have consultations with them to discuss any issues, or have specific treatments. This improved the service for the patient as they had the opportunity to get the information and support they needed at one visit.

Medical staffing

- The number of medical staff in some clinical specialities had increased, such as respiratory medicine. Consultants told us for outpatients this meant they could do more clinics because there were enough middle grade doctors to cover the wards, out of hours work and the outpatient clinics.
- There was one consultant haematologist in the hospital. This resulted in a shortfall in provision, particularly out of hours cover, which had been included on the risk register since September 2014. There were plans to develop a shared post with other hospitals in the area and in the meantime locums were used with a rotational on call system for consultant cover which included other hospitals. We were told this temporary arrangement was not ideal, but it had not resulted in any patient safety incidents.
- The number of staff working in the radiology department had not increased although we were told the workload had increased, which was leading to delays. The manager of the service told us there had been a redeployment of staff which meant there was sufficient cover in each area to provide a 24 hour seven day service.
- Staff in the radiography department discussed how recent changes to deployment into specialised areas had resulted in reduced numbers and staff not being able to work across different departments in order to assist at busy times. This had increased patients waiting times and the risk of errors due to time constraints. Concerns had been reported to senior managers, however there had been no changes made. Radiography staff were unaware of plans to increase these numbers.

Administration staffing

- Since the last inspection there had been an increase in the numbers of administration staff in most departments. This included medical secretaries, telephonists, receptionists and staff making appointments. This had led to a much improved administration process for the whole of the outpatients department resulting in quicker appointments from referral, increased ability for patients to contact administration staff and quicker receipt of letters by GPs and other professionals for further referrals.
- Where quick results were necessary and administration staff shortages may have impacted on this agency and bank staff had been used. This included for them to clear the backlog of letters to patients which had built up at the time of the last inspection.
- The administration staff said they had received more training in the past few months including that for the electronic patient records system if required.
- Operations managers told us the telephone call centre did not function as it should. There were concerns about the time to answer calls and the quality of response given. There were plans to improve this with a new manager having recently joined and recruitment for

additional telephone operators underway. Customer service training was planned in conjunction with the trusts' education department who had spent time in the department in order to tailor training to their needs.

Major incident awareness and training

- Nursing and diagnostic services staff in the outpatient department were aware they would have a significant role in a major incident. They knew which areas would be used and their own responsibilities.
- There had been simulation exercises and changes made to the plans following these if required.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Policies and procedures met with recognised national and international guidance and staff were included in changes to departmental guidance as appropriate. There was evidence of learning from other hospitals and between departments to share good practice. During our previous inspection we found there was a delay in patients receiving their letters following consultation. This had been resolved and there was no delay at the time of this inspection. There was good multi-disciplinary working within and between various departments to facilitate good outcomes for patients and use local expertise. Most staff had received training about the management of patients with reduced mental capacity. However not all staff had received this training which led to some being unclear how this may impact on their role in providing care and support.

There had been changes to the procedures and practices of various areas of the outpatient departments over the last 12 months. Despite this there was no ongoing audit programme in place to monitor the progress of the changes. A new appraisal system had been introduced but was not yet in use. There were some clinics in the evenings and at weekends; however there were plans to increase most clinics to three sessions per day and more on Saturdays.

Evidence-based care and treatment

- The 5 steps of safer surgery protocol had been introduced in January to ensure minor procedures carried out in the outpatients department complied with NICE guidance. Three audits had been completed to assess compliance; however staff were unaware of the outcome of these at the time of the inspection.
- Managers told us there was no specific audit programme in place for the outpatient department. This meant the changes to the procedures within the department were not being audited to assess and monitor their effectiveness.
- There was a monthly meeting for radiology staff to present audits they had completed. This included clinical audits and those to improve the quality of the service such as markers on plain films for correct identification.
- Managers told us if they needed to change policies in their practice area the mechanism to do this was straight forward. An example of this was changes made to the radiology department's standard operating procedure which was quickly reviewed and agreed to enable discussion with staff and changes to be made in a timely manner.
- Where changes were identified as necessary such as to the fracture clinic, learning from other services was part of the planning for change. For this clinic a model of care by another UK hospital was being examined as a possible template for improvement.
- Nursing and medical staff were aware of the relevant guidelines to their area. This included the epilepsy clinical nurse practitioner who stated they worked in line with NICE guidance CG137 (The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care). Nurses with responsibility for pre-operative assessment were involved in the review of protocols such as the enhanced recovery programme for fractured neck of femur. This met NICE guidance and had been approved by a multi-disciplinary team including physiotherapist.
- Nursing and diagnostic staff knew how to access the policies and procedures pertinent to their areas. Some had both written copies and could access them on the hospital internet.

Pain relief

- Nursing staff were aware of the need to discuss pain management with patients if applicable to them and their care. This included following invasive procedures, such as those provided in the orthodontic clinic.

- Medical staff could prescribe pain relief if required following a procedure.

Patient outcomes

- A new system had been implemented to reduce delays for patients in receiving the information, treatment or further referral they required following an outpatient appointment. At the end of each clinic, appointed staff collected the relevant forms from the doctors with the outcome of the appointment. These were collated and aligned to the attending patients and any outstanding forms were followed up by administration staff with the appropriate doctor. Previously these forms were collected by nurses at the end of the clinics and passed to administration staff with no process for follow up of outstanding forms. This had led to delays in referrals for treatment and further appointments.
- Secretaries told us there had been a vast improvement in the administration processes which resulted in letters being sent out within agreed timescales. The timescales were two days for urgent letters and five days for non-urgent letters. There was no backlog of letters waiting to be sent out at the time of our inspection.
- Secretaries told us patients received the results from diagnostic tests in a timely manner and the target of two days for urgent results and five days for others was being met. We saw on 28 April 2015 letters were being written for appointments held on 21 April 2015 which met the five working day target.

Competent staff

- A new appraisal system had been introduced in April 2015 which had been developed to include the values and behaviours of staff as well as work performance. Management staff who were to complete these appraisals for their staff had received training on how to use the new system.
- The appraisals in the radiology/radiography department had been delayed until the new system was introduced. 62.4% had been completed which meant not all staff had the opportunity to discuss their performance with their manager in the past 12 months.
- Band 5 nurses were involved in the mentor programme for newly recruited and newly qualified nurses. This meant new staff were supported during the first few months of their employment and the band 5 nurses had an opportunity to expand their role.
- The competence of staff to use some specific equipment and medical devices such as echo cardiograms was assessed.

Multidisciplinary working

- There were examples of multi-disciplinary working between the service and other hospitals when this was required which included specific services such as breast care and hospital wide services such as haematology and pathology. Some meetings were held by video link with specialists from the other hospitals and some meetings were held on-site. This showed the hospital was using the expertise of specialists in other hospitals to improve their patients care.
- Specialist nurses told us they were part of Manchester wide groups where they could discuss patient diagnosis with other specialists at multi-disciplinary meetings via video link. One example of this was the gastro-intestinal specialist nurse who linked with the local cancer specialist centre to discuss patients and their care and treatment needs.
- Medical, nursing and diagnostic staff discussed good working relationships with their colleagues from other teams. They said this had improved greatly over the past few months with increased formal meetings open to all grades of staff which were department wide and not role specific.
- Nursing and medical staff described how the administration staff were now included as part of the team which had improved communication between them. Administration staff said they now worked as part of the team instead of in isolation. There were plans to develop this further such as named staff scheduling a specific consultants' appointments.

Seven-day services

- Staff in some areas, such as the ear, nose and throat clinic (ENT) said they had introduced evening and Saturday clinics. Staff in individual departments had planned for how they could extend their clinics to include more evening and Saturday work.
- There were few clinics running on a Sunday although a breast care clinic had done so and ran three clinics per week at 5pm to 8pm. This meant there was an increase in some clinics when required.

Outpatients and diagnostic imaging

- Volunteers provided support during evening clinics which meant the mobility scooter was available for people at this time. This was as a result of staff being listened to at the engagement meetings.
- Radiography tests were available seven days per week 24 hours per day. A consultant radiologist was available on site from 8am to 5pm and on call off site from 5pm. At nights and weekends the electronic reporting of radiology films was outsourced to a company in Australia which meant they could report through the night.

Access to information

- The records required for staff to deliver the care to patients were available in the clinics. There were no temporary notes being used and we were told it was rare that they were necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing and medical staff told us they had completed training to help them understand their role in assessing the capacity of patients prior to consenting to treatment. Examples were given of where this had been necessary in the past.
- Nursing staff reported that the training they had completed in the Deprivation of Liberty safeguards had helped their understanding of this legislation.
- Staff in the phlebotomy department had not received training on the Mental Capacity Act or the Deprivation of Liberty safeguards. They were unclear as to how to manage the care of a patient who may, through behaviours, appear to not be consenting to having blood samples taken, especially if a family member or other carer was present and providing physical assistance. This could lead to patients having invasive procedures without their consent.

Are outpatient and diagnostic imaging services caring?

Good

Nursing and medical staff treated patients with respect, kindness and patience. They protected their privacy and dignity and confidentiality of information. There was recognition of the need for private discussion at some clinics and this was discreetly facilitated.

Patients told us they received clear information prior to their appointment and knew what to expect. There was provision for patients to have a family member or carer accompany them to the consultation and diagnostic tests if required.

Compassionate care

- Patients told us the staff were very helpful, kind and patient when they were assisting them.
- We saw staff from various roles and of all grades stopping in the corridors and waiting areas to offer assistance in a polite and friendly manner.
- All medical, nursing and administration staff spoke respectfully to patients, including when they called them into the clinic rooms.
- Clinic staff said the waiting times in clinics could be lengthened if patients required a longer appointment due to needing explanations or discussions about their care.
- The privacy and dignity of patients was protected. The curtains around cubicles were closed and signs to remind staff not to walk in were in place. We saw some staff knocked on doors before entering a consulting room, but not all staff did this which could result in a lack of protection of privacy.

Understanding and involvement of patients and those close to them

- People said they were kept informed of the waiting times in the clinics. Although some did not understand why they had to wait over an hour for their appointment, they were glad they had been informed of the delay.
- If there were delays we saw staff informed patients and offered to find them in the café area if they wished to

leave the waiting room for refreshments. This showed an understanding of the patients' needs. Patients were given written information about their appointment prior to the day. Patients told us this had improved recently and they received the information they required.
- The information patients received included if they might need tests to be carried out during the appointment and approximate timings for this. This meant they knew in advance if they may need to stay longer.
- Patients and staff said and we saw that patients could take a family member or carer into a consultation with them in order to assist them or reduce anxiety.

Emotional support

- Clinic staff said the waiting times in clinics could be long if patient's were given bad news. They said they would not rush this process, but take the necessary time to explain concerns, results of tests and any further treatments required.
- There were rooms in most clinics where patients could be taken to be given bad news and where they could spend time with family members if required.
- In specific cancer care clinics, a McMillan nurse was part of the team in order to provide additional advice and support for those who received a diagnosis of cancer.

Are outpatient and diagnostic imaging services responsive?

Good

There were systems in place which meant patients could be seen at Tameside hospital instead of travelling to specialist centres in Manchester. One stop clinics were available to reduce the amount of visits to hospital a patient would need for consultations and diagnostic tests.

There were improvements to the access for patients in the outpatient department since the last inspection. This included reduced waiting lists and the service was better than the England average in meeting the two week cancer wait targets and urgent GP referrals. However, there remained long waits for patients in some clinics. Staff supported patients with complex needs and could access additional help if required. There was evidence that staff learned from complaints.

Service planning and delivery to meet the needs of local people

- Some clinics were organised so that patients could attend their appointment and have associated tests carried out in the same visit. This meant they did not need to attend twice and patients told us this had improved in the past year.
- Joint working arrangements with the local cancer specialist centre meant that patients could attend Tameside hospital instead of having to travel to central Manchester.
- For example, in order for patients in the local area to access cancer services without the need to travel to the local cancer centre in Manchester, one stop clinics for head and neck lumps and breast care were available. Patients could see the consultant, have tests taken, wait for results and receive a treatment plan in the same visit. This meant patients received a timely service without the need to travel.
- The radiography department was taking part in a study which used magnetic resonance imaging (MRI) and computerised tomography (CT) to conduct a post mortem examination. This met with some multi-faith requirements of the local population.
- Patients told us the waiting areas where mostly pleasant places to wait especially the blue clinic area which was bright and spacious.
- In the clinics where people waited up to and over one hour there were not always adequate waiting areas and seating available. As a result, chairs were put into the corridors which could create a potential hazard.

Access and flow

- Waiting lists for most clinics had improved since the last inspection. The aim for first outpatient attendance from referral was six weeks. Information provided by the trust was that 15 out of 38 clinics had a waiting list of six weeks or less. This meant that patients attending 60% of clinics were waiting longer than the trusts' target. However, all the remaining clinics had a waiting time of fourteen weeks or less which was lower than the national recommended referral to treatment time of 18 weeks.
- The outpatient manager said the aim was for each clinic to develop a plan to reduce the waiting list for a patient's first appointment to six weeks or less. Some specialist clinics, such as audiology, had set their own

waiting time targets. For the audiology clinic the aim for a first appointment from referral was within two weeks. At the time of the inspection patients were seen within four weeks and we were told this was due to staff shortages through sickness.

- The two week cancer waiting times in the breast care clinic between April 2013 and April 2014 were 98.4% which meant most patients were seen within the recommended timescales.
- In order to improve the access to appointments and reduce the waiting times a new role of "scheduler" had been introduced. These six staff managed the waiting lists for specific clinics; having an overall view of the upcoming appointments, availability and required changes such as through cancellation by patients or doctors. The plan was for them to engage with specific consultants to improve their understanding of how individual clinics ran and what adjustments may be required for certain procedures.
- A waiting list steering group had been set up. From this group, information packs were produced which contained information about the waiting lists including individual patient details so that delays could be followed up.
- There was a trial taking place whereby the "schedulers" telephoned patients to agree the date and time of appointments, prior to sending their letter out. This was designed to reduce the cancellation rates for patients. From September 2014 to December 2014 the trust's appointment cancellation rate ranged from 12.9% (September) to 16.2% (December). According to the trust, 75% of clinic cancellations were due to annual leave, study leave, sick leave or being on call, with annual leave the reason in more than 50% of the cancellations. The majority of the time, cancellations were made more than 6 weeks prior to the appointment date
- Some consultants preferred to triage their own referrals prior to the appointments being made, whereas others did not. Previously this had delayed some appointments being made, however there was a process in place now to track these appointments and encourage quick appointments to be made.
- As part of the changes to reduce the waiting list times, the outpatient manager had introduced a system for following up any appointments which were outside of the target times. This helped them to understand the reasons, ensure records were correct and discuss actions to reduce recurrence with the clinician responsible.
- A new system for monitoring the usage of consulting rooms in the outpatients department had been introduced. This electronic system meant that vacant rooms were identified and additional clinics could be arranged to reduce the waiting list times. In the four weeks in March 2015, an additional 41 clinics had been booked in core time.
- There were electronic screens for people to register their attendance at clinic. These were present in both main entrance areas, were clear and easy to use and had a multi-language function. There were receptionists in both areas also if people preferred this. This meant people could check in quickly, with a choice of help if required.
- In some clinics there were televisions that displayed waiting times. In those without a television staff were seen to verbally inform patients of the waiting time and offer apologies.
- In some clinics such as ophthalmology and fracture clinic we saw people had to wait up to one hour to be seen. Staff reported this could be up to two hours at times and they were unaware of any actions being taken to reduce these waiting times. An audit of start times for the clinics was underway to assess the reasons for delays and the impact this had on the running of the clinic.
- The monthly rate of appointments not attended was between 8.5% and 11% which was higher than the England average of 7%. There was a text reminder service for patients which they told us they had received and said this helped them to keep their appointments.
- A new administration manager had been appointed to oversee the appointment booking system and the telephone system in the department. Staff said they had streamlined the processes and were monitoring performance on an ongoing basis.
- In order to provide timely services for patients who may require wound care some drop in clinics were available, such as that in the breast care clinic. To help facilitate reduced waits, health care assistants had completed extended role training to carry out tasks such as wound dressings.
- We were told by staff in some wards and departments there were delays in the reporting of some radiological

tests. The trusts' target for reporting all tests for two week wait cancer patients was 95% to be reported within 72 hours. Information provided by the trust showed they had achieved 75% within this timescale. Urgent requests should be reported on within five days and 78% was achieved within the outpatient department. In order to assist the timely reporting of potential abnormalities a new system of identification had been devised. The radiographer used a red dot on the report and informed the consultant concerned if they saw anything of concern on the results. This meant whilst there were delays, actions had been taken to reduce the risks to patients.

Meeting people's individual needs

- Translation services and written information in languages other than English and other formats were available on request from the customer services area in the South entrance. However, these were not on display and there was no indication for people that information in other languages was available.
- Staff said they could book a face to face translation service in advance of an appointment and would do this wherever possible.
- Support for people with hearing difficulties included interpreters for British Sign Language if required.
- Should a person living with dementia attend for an appointment they could be supported by their carer or family member. In one clinic people with such needs were categorised as "complex" which meant they had a longer appointment time and had open access to the clinic.
- Information displayed on notice boards, such as that in the audiology department, was informative and comprehensive providing information about a specific topic. However, this information was seen in English only.
- One clinic where minor procedures were carried out had made adjustments for people with learning disabilities which would help them to be less anxious. This included visits to the clinic beforehand to view the environment and equipment and the use of pictures to explain procedures.
- Patients told us they received clear information about their appointment before the date. This included details of where to obtain further advice and help if it was required.
- There was limited signage around the hospital to direct people to the various outpatients departments and we saw people waiting in the wrong area. Signs to direct people from one place to another were also lacking. For example when people required any tests following their consultation. As a result we saw people asking for directions in the hospital corridors.

Learning from complaints and concerns

- Information posters about how to make a complaint were on display in the waiting areas of the outpatient departments. Patients said they knew they could complain if they wished and were aware of the information available.
- In response to patients' comments about being unsure which staff members to approach, the nurse in charge of specific areas wore a red armband with "team leader" written on it to denote they were in the lead position in that clinic area.
- Following the implementation of a new electronic records system, there had been issues with patient appointments getting lost in the system. As a result, a new team of staff had been introduced to "track" every appointment for every patient. This team monitored the patient's journey within the system and this had resulted in patients' referrals not being delayed.
- We were told there had been complaints about the service patients received when they rang the outpatients department about appointments. There were plans to improve this service including tailored training for staff and additional recruitment. The call centre had extended the opening hours twice weekly to 6.30pm and there were plans to open until 7pm Monday to Friday.

Are outpatient and diagnostic imaging services well-led?

Good

Staff in all roles and at all levels were positive about the changes that had taken place in the management of the outpatient and diagnostic services department. Staff felt part of the planning and there were mechanisms in place to ensure they were included. Staff told us that senior managers welcomed and listened to their contribution. They spoke highly of the leadership both in their

immediate area and in the outpatient department as a whole. There was a vision to provide a better service to patients including reduced waiting times and an increased number of clinics out of hours.

There were plans for increased public engagement with focus groups set up in consultation with local community groups. However, some staff in the radiology department were less positive about recent changes which they felt had taken place without consultation and had resulted in a poorer service for patients.

Vision and strategy for this service

- Senior managers told us that in the past, they had not been included in the forward planning of the service and had been unaware of some issues. However, they now felt a part of the planning for the future and were included in developing plans for the service.
- One of the visions for the outpatient department was to provide three sessions per day, morning, afternoon and evening as well as expand the number of clinics held on Saturdays. Staff of all grades were aware of this vision and their part in its development.

Governance, risk management and quality measurement

- Individual clinic managers told us the department risk registers had been upgraded and they were now easier to use and keep up to date. They were aware of the risks for their specific areas and the plans to reduce these risks.
- Staff in the radiography department said they did not feel things entered on the risk register, such as reduced staffing numbers, were acted upon. They were concerned these risks remained without positive change. We discussed these concerns with the service manager who told us the concerns had been raised due to changes in staff work patterns rather than because they presented a patient safety risk. However, during our inspection staff were clear they felt it did impact on patient safety and felt they were not being listened to.
- Whilst there was some individual audits in specific clinic areas, there was no formal audit process for the outpatient department as a whole.
- Governance meetings took place where relevant. During these meetings staff discussed issues, progress and challenges in their areas. This included incidents and complaints with associate learning and changes to practice.

Leadership of service

- Staff described having confidence in the trust board and nursing manager who they described as approachable and positive in their support.
- Senior staff told us they were very well supported by the outpatient business manager whom they met with on a weekly basis. They said this was an opportunity to discuss their service and it increased their confidence whilst working in this role.
- The nurse managers in the outpatient departments had completed leadership training. One manager described this as empowering and said it had helped in their role and in communication with other departments.
- The outpatient matron discussed how the leadership of the service had been devolved to the nurses and administration staff through increased discussions, the development of multi-disciplinary teams and encouragement for them to present ideas for change. This was being done in conjunction with the patient experience lead in order to ensure the focus was on improving the service for patients.
- A management review of the service took place every Monday conducted by the management team including nursing, administration, and business managers. This was designed to discuss the week ahead, progress on actions and developments and any specific issues.
- A meeting of nursing and administration staff took place every Tuesday morning which was open to all grades of staff. We were told this had improved the team working within outpatients as previously there was no formal mechanism for communication.

Culture within the service

- Senior outpatient managers described their management team as being supportive, inclusive and not dictatorial. They said they had responsive senior colleagues.
- There was a culture of openness where staff could discuss any concerns they had. We were told senior managers did visit the clinic areas to see concerns for themselves.

Outpatients and diagnostic imaging

Public and staff engagement

- Staff spoke positively about the increase in engagement with them, by senior managers, in the past few months. They said there had been engagement meetings held where all staff were welcomed and their ideas were invited and listened to. Senior staff regularly walked around the outpatient departments, including the administration staff areas and suggestion boxes had been introduced.
- Following these meetings specific engagement groups had been developed including outpatient department nurses, phlebotomists and those working in the fracture clinic. These were to share ideas and plan future developments.
- Staff in some outpatient clinics told us they had previously felt isolated from the management of the service; however this had much improved in the past few months. They were now invited to attend meetings such as the operations management meetings and wider department team meetings. They said this had made them feel more valued and included.
- Minutes from these engagement meetings were available for staff in their rest room which meant they could access the information discussed even if they could not attend.
- The Friends and Family Test had been introduced to outpatients departments in the past few weeks. As this had only recently been implemented, there was no data available at the time of the inspection.
- A focus group had been set up with the first meeting to take place following the inspection. This included local GPs, patients who used the service, the outpatient manager, staff from the appointment booking office and the outpatient nurses. This was designed to improve engagement with the local population and other stakeholders.
- Since the last inspection when medical secretaries told us they felt isolated and not included, the trust management had improved communication and involvement. The chief executive officer and other senior staff had visited the administration building, talked to staff and agreed actions which staff said had been completed. This communication and involvement was ongoing with weekly meetings of the immediate managers and monthly meetings with the trust board.
- Staff in the radiography department said the recent changes in the deployment of staff had been done without consultation and they did not feel it was a positive change for patients. They had discussed this with managers, but did not feel they were listened to.

Innovation, improvement and sustainability

- There had been a lot of positive changes in the outpatient department generally and in specific clinics. Staff told us the pace of this change was adequate for them to adapt as necessary**.** They said this rate of change was sustainable as long as it was required.
- Staff said the re-introduction of receptionists in both main waiting areas had been as a result of them being consulted and listened to by managers.
- There was a plan to assist the improvements in the work of the secretaries. This included weekly meetings, increase in staff and recruitment to new posts. This was to aid the sustainability of the improvements which had taken place since the last inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The trust must:

- Ensure that medical staffing is sufficient and appropriate to meet the needs of patients at all times including out of hours.
- Improve patient flow throughout the hospital to reduce the number of patients transferred at night and ensure timely access to the service best suited to meet the patient's needs, particularly in A&E and medical care services.
- Improve the completion levels of mandatory training and appraisals for nursing and medical staff.
- Ensure that medicines, particularly controlled drugs are stored, checked and disposed of in line with best practice in all areas but particularly in A&E and Outpatients.

Action the hospital SHOULD take to improve

The trust should:

In urgent and emergency care services:

- Ensure staff are trained in assessing patients using NEWS and MEWS and accurately record scores.
- Ensure all action plans in relation to CEM audits are specific and measurable.
- Ensure pain scores are routinely recorded for all patients and pain relief is prescribed and administered in a timely manner.
- Ensure all staff are aware of their responsibilities in relation to safeguarding and consent in relation to the mental capacity act and deprivation of liberties.

In medical care services:

- Take action to improve outcomes for patients particularly those with diabetes, heart failure and patients who have had a stroke.

In surgery:

- Improve surgical site infection rates for patients following orthopaedic surgery.
- Improve theatre efficiency to reduce delays in theatre session start times.
- Improve the timeliness of responses to patient complaints.
- Improve compliance against 18 week referral to treatment standards for ENT and trauma and orthopaedics for admitted patients.
- Improve the number of patients whose operations were cancelled and were not re-booked within the 28 days.

In critical care:

- Improve the number of patients admitted to the critical care services within four hours.
- Reduce the number of out-of-hour patient discharges.
- Improve the timeliness of responses to patient complaints.

In outpatients and diagnostic imaging services:

- Continue to take action in improving waiting times in all clinics.
- Ensure there is a system in place to audit changes to practice and procedures in order to monitor their effectiveness.
- Ensure all staff are familiar with, suitably trained and competent to use resuscitation equipment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing. Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed. This is because there was a shortage of medical staffing in some areas, particularly out of hours. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing. Persons employed by the service provider did not always receive appropriate training and appraisal. This is because mandatory training completion levels and appraisal rates for nursing and medical staff were variable across the service.

This section is primarily information for the provider

Requirement notices

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment. Care and treatment was not always provided in a safe way through the proper and safe management of medicines. This is because medicines, particularly controlled drugs were not always stored, checked and disposed of in line with best practice in all areas, particularly in A&E and Outpatients. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12, (2) (g)