

# Tameside and Glossop Integrated Care 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

Good



Urgent and emergency services

Good



Medical care

Requires improvement



Surgery

Good



Critical care

Good



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Good



Outpatients and diagnostic imaging

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Tameside General Hospital is part of Tameside and Glossop Integrated Care 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 528 beds.

We carried out this inspection to see whether the hospital had made improvements since our last inspection in April 2015. Following our inspection in April 2015 we rated the hospital as requires improvement overall. We judged the hospital to be requires improvement for safe, effective and responsive and good for caring and well led.

We visited the hospital as part of our comprehensive announced inspection on 8 to 11 August 2016. We also carried out an out-of-hours unannounced visit on 18 August 2016. The inspection team inspected the following core services:

- Urgent and emergency services
- Medical care services (including older people's care) including the Stamford Unit
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young People
- End of life care
- Outpatients and diagnostic services

The Stamford Unit is a recently opened community facility to support patients who are determined to be medically fit for discharge. The patients require further support in a non-acute setting to be assessed and discharged into the community. However, we did not rate the service provided as the unit had only been opened for three weeks prior to the inspection and we did not have sufficient data to fully consider this.

A separate report is available with regard to this service.

Overall, we rated Tameside General Hospital as 'good'. We noted that there had been significant improvements in some areas since our last inspection

Our key findings were as follows:

### Access and Flow

- Access and flow in the emergency department remained a continuous challenge.
- From March 2015 to April 2016, the trust did not meet the Department of Health Standards to

Transfer or discharge patients within four hours of arrival and the decision to admit patients within four to 12 hours for nine out of 12 months.

- Data showed the percentage of patients leaving before being seen was consistently worse than the England average for same period.
- Again, from March 2015 to April 2016, the total time patients spent in the emergency department (average per patient) was consistently worse than the England average.
- There were 211 black breaches from May 2015 to May 2016. Black breaches occur when the time from an ambulance's arrival to the patient being handed over to the department staff is greater than 60 minutes.

# Summary of findings

- The trust had an escalation process in place for periods when there was increased demand. The purpose of this process was to ensure the effective management of the trust's bed capacity and to give staff clear processes and triggers to follow. We found that the actions set out in this process were followed when increased pressure was experienced.
- There were bed meetings held three times a day. These meetings were attended by senior nursing staff from the ward areas, patient flow team and the emergency department team.
- Between February 2016 and July 2016, there were a total of 526 medical patients admitted across the three surgical wards (medical outliers). Medical outlier patients were seen daily by medical doctors. In the course of the inspection, we were informed by ward managers that it was very rare for a surgical patient to be placed on a medical ward.
- There was a focus on discharge planning on all the wards. Following multi-disciplinary meetings discharge plans were made for each patient based upon their progress.
- The trust had made significant improvements with regard to Referral to Treatment (RTT) waiting. In terms of RTT standards, the trust was now at mid-table level in terms of achieving standards and had previously been in the bottom six trusts nationally.

## Cleanliness and Infection control

- Generally patients were cared for in a visibly clean and hygienic environment.
- Staff followed the trust's 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 for surgical site infections showed the hospital performed similar to or better than the national average for the proportion of patients that acquired surgical site infections following surgery.
- However, in maternity and gynaecology quarterly infection prevention and control audits were completed and ward 27 had scored 83% in April 2016. Issues remained during the inspection, which had not been identified or rectified following the ward audits. These included scuffed wooden surfaces, doorways and equipment which could not be thoroughly cleaned, tears in a seat cover, chipped paint and loose plaster, rusty waste bins and a perished area on a cot mattress. At the unannounced inspection a more thorough audit had been completed and some items had been removed or replaced. A programme of deep cleaning refurbishment was planned.

## 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.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave.
- The number of midwives were appropriate to meet the needs of the patients in both maternity and gynaecology services.
- However, nurse staffing levels, although improved, remained a challenge in some areas. This was particularly the case in medical care services.

# Summary of findings

- We were able to review a report produced on the 27 April 2016. The report showed a number of wards in the medical directorate which were below 80% fill rates for qualified day staff. The report highlighted issues in ward 41, 44 and 46 where qualified fill rates were between 79% to 74%.
- During the unannounced inspection, there was a shortage of two qualified nurses on 41, one bank nurse was deployed and the band seven nurse in the unit moved a member of staff from their ward to cover the remaining shortfall. This meant they were unable to carry out the quality safety round conducted by the band seven nurse each evening to ensure their ward remained safe. They had informed the wards and were available for telephone contact.
- Of the nine band 6 and 7 paediatric nurses on the children's unit all had completed Advanced Paediatric Life Support (APLS) with the exception of two new staff. However, only three were up to date at the time of our inspection. Plans were in place for three staff to attend a course in September 2016 and three in January 2017. Risk was mitigated by the on-site presence of a paediatric registrar at all times. Advanced paediatric nurse practitioners, working in the paediatric emergency department had also completed APLS.

## Medical staffing

- Medical treatment was delivered by skilled and committed medical staff who worked well with other disciplines to deliver safe quality 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 (37% compared with the England average of 42%). The proportion of registrars was also below the England average (27% compared with the England average of 36%).
- These figures were an improvement from last year and the urgent and emergency care department had slightly above the England average number of consultants.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants when needed. 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.

## Mortality rates

- Following concerns that the trust was either a risk or an elevated risk for the some mortality outliers including gastroenterological and hepatological conditions and procedures, infectious diseases, nephrological conditions, vascular conditions and procedures, a process to review every death had been started by the trust. This provided an assurance of safe and quality care delivery and was recognised by the clinicians as not just a box ticking exercise.
- Mortality review outcomes were discussed at a mortality steering group chaired by the medical director, which fed into the service quality and operational governance group and the quality and governance group for oversight and scrutiny. Lessons learned were disseminated through the divisional governance structure to enable appropriate actions to be embedded and learning from mortality reviews to be shared by divisional teams.

## Meeting the needs of disabled patients

During the inspection, we carried out a pilot inspection looking at how the trust met the needs of disabled people. The main findings are contained in the responsive section of the provider report. However, below is a summary of our findings:

- A bespoke system electronically tracked every patient with learning disabilities in the hospital, which was overseen by a named lead nurse in learning disabilities.
- All patients with a learning disability were referred to the learning disabilities nurse by fax on admission.
- When a patient with a disability was moved, an email would be sent to ward managers reminding them to be mindful of reasonable adjustments for that patient. Patients would also be put on a reasonable adjustments care pathway, and where necessary their carer had their own care pathway.

# Summary of findings

- There was a team of volunteers who provided mobility scooters by request and supervised their use throughout the trust so patients with mobility difficulties could move through the site easily. There were also volunteers who would sit with sensory impaired patients to guide them through their hospital journey on request. Volunteer help could be booked in advance by phone or at any reception desk.
- The hospital had two wards designed for dementia patients, which included dementia friendly 'reminiscence rooms'. Material and information was also available throughout the rest of the hospital, such as 'twiddle-muffs' to keep patients occupied and engaged. Every ward we saw had a comprehensive information board on dementia with contact details for the admiral nurse. However, there were no set activities for dementia patients at the time of inspection.

We saw several areas of outstanding practice including:

## **Urgent and Emergency Services**

- The department's practice development nurse provided excellent support and education to the staff within the department.
- The department's handling of the major incident, which occurred during the inspection, was excellent and ensured that patients were treated in the most appropriate and safe manner.
- The divisional leaders made great efforts to ensure that they were visible at all times, especially during times of pressure.

## **Surgical Services**

- Ward staff applied 'reasonable adjustment' principles for patients with learning disabilities and specific care plans were in place to provide guidance for staff. The care plans took into account factors such as the environment, communication (e.g. use of communication books or easy read leaflets), staffing, equipment requirements and procedures (such as booking patient first or last on list).

## **Maternity and gynaecology**

- A programme for supporting and informing pregnant women with alcohol consumption problems had been developed. MAMA (Maternal Alcohol Management Algorithm) was managed by the safeguarding lead midwife. This provided pathways into related services in the community including rehabilitation day services, community support and detoxification support.

## **End of life care**

- The trust had direct access to electronic information held by community services, including GPs. This meant hospital staff could access up-to-date information about patients, for example, details of their current medicine.

## **Outpatients and diagnostics**

- The radiology department offered a "Virtopsy Service". This virtual post-mortem service was used when a CT scan could determine the cause of death. This speeded up the process of determining cause of death and respected the religious and cultural needs of some of the local population. Scans were carried out at night and reporters were experts in reporting on virtual post-mortems. Deceased persons were transported to the unit via a private corridor. The trust were one of the first in the North West to offer this service.

However, there were also areas of poor practice where the trust needs to make improvements.

## **Action the hospital MUST take to improve**

### **Urgent care**

- Ensure that patients can access emergency care in a timely way.

# Summary of findings

- Ensure all staff receive mandatory training at the required level and within the appropriate time frame.
- Ensure that fridges used to store medications are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.

## **Medical Services Including Older People**

- Ensure there are appropriate numbers of nursing staff deployed to meet the needs of patients.

## **Children and Young People**

- Ensure all equipment used to provide care or treatment to a service user is properly maintained.
- Ensure that there is one nurse on duty on the children's ward trained and up to date in Advanced Paediatric Life Support on each shift.

In addition the trust should:

## **Action the hospital SHOULD take to improve**

### **Urgent and emergency care**

- Ensure that staff receive their annual appraisal.

### **Medical services including Older people**

- Ensure children's safeguarding training across all professions within the medical directorate is up to date.
- Look to reduce the number of medical patients being cared for on surgical wards.
- Continue to monitor staffing arrangements on wards.

### **Surgical Services**

- Take appropriate actions to improve mandatory training compliance rates.
- Take appropriate actions to reduce the number of cancelled elective operations.

### **Maternity and gynaecology**

- Ensure the improvements in the infection prevention and control measures and the environment on ward 27 should continue.
- Emergency medicines should be safely stored in the obstetric theatre in line with trust's policy for the safe use of emergency medicines.
- Appropriate actions should be taken to improve the mandatory training compliance rates for infection control and children's safeguarding.
- Records should be securely stored in the ward areas.
- Ensure that a deteriorating patient's care was managed in line with the trust's policy.
- Continue to make improvements in the completion of the safer surgery checklists.
- Develop a system to ensure patients received required home visits by the community midwives.

### **Children and Young People**

- Ensure recording of fridge checks include the maximum and minimum temperatures in accordance with national guidance.
- Ensure dates of cleaning and safety checks are legible on equipment.
- Review documentation for infants when intervention is reduced to high dependency or special care.
- Ensure the security and confidentiality of medical records in the paediatric outpatients department.
- Ensure PEWS documentation is completed and audited to improve compliance.
- Ensure the neonatal unit consistently collect patient feedback using the NHS Friends and Family Test.

# Summary of findings

- Ensure inpatient discharge summaries and outpatient clinic letters are sent in a timely way.
- Ensure regular staff meetings take place on the neonatal unit.

## End of life care

- Consider how it can increase uptake of the use of the individual care plan for end of life care patients.
- Consider how it can encourage improvement in the accuracy and completeness of DNACPR forms, including the undertaking and recording of mental capacity act assessments, the recording of best interests decisions, and discussions with patients and their relatives.
- Consider reviewing information held within the palliative rapid discharge link nurse files held in wards and units across the trust to ensure the information held is accurate, up to date, and in line with prescribing and dosage guidelines for anticipatory medicines.
- Consider what actions it could take to further increase the proportion of end of life care patients dying in their preferred place of care.
- Consider what actions it can take, within its control and where requested, to increase the percentage of end of life care patients discharged within the timescales of the rapid and fast discharge process.

## Outpatients and Diagnostics

- Continue the active recruitment of radiologists to meet actual WTE requirements and maintain safe staffing levels.
- Resolve the issue of allied health professionals being unable to accurately record mandatory training levels.
- Carry out an infection control risk review of positioning aids foam pads in radiology, to ensure that the risk of infection is minimised.
- Ensure that all entries on patient notes are signed and dated.
- Continue to increase the numbers of staff who have undertaken children's safeguarding training to meet trust targets.
- Review version controls on Local Rules for Radiation Protection and ensure that all staff have signed them to indicate that they have read and understood them.
- Continue to seek a solution to the lack of an electronic system that interfaces with local GP surgeries.
- Continue to seek viable solutions to reduce "Did Not Attend" (DNA) rates.
- Continue to seek solutions to improve "Referral to Treatment" (RTT) times so that all clinical pathways met national standards.
- Review the consultation room in clinic nine where the door opens outwards to improve privacy and dignity for patients.
- Review the children's play area in outpatients clinic's six to nine to see whether this could be better located or children observed and kept safer.
- Improve patient knowledge of how to access PALS should they need to do so.

## Professor Sir Mike Richards

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

Urgent and Emergency services were good at the Tameside General Hospital with some elements that required improvement:

- We found that some patients experienced delays in accessing these services due to pressures on the department.
- Staff were able to report incidents and were knowledgeable about the types of incident they should report. We saw evidence that learning from incidents and complaints was routine and this learning was disseminated widely.
- Infection control was effectively managed and the department was visibly clean.
- Nursing and medical staffing was sufficient to meet patient's needs.
- Patients accessing the emergency department received effective care and treatment that followed national clinical guidelines and was tailored to their individual needs. This care was delivered by competent and professional staff. The department participated in local and national audits.
- Staff sought appropriate consent from patients before delivering treatment and care and were knowledgeable about the Mental Health Act and considered this, where relevant. Staff treated patients with kindness, dignity and respect and provided care to patients whilst maintaining their privacy and confidentiality. Patients spoke very positively about the manner in which staff treated them.
- The emergency department planned its services to meet the individual needs of the local population it served.
- The trust saw less than 95% of patients within four hours of arrival for 12 out of the 12 months we reviewed. However, the staff and senior



# Summary of findings

management team in the department worked collaboratively to manage increased pressure and had effective measures in place to ensure patients received high quality care.

## Medical care

Requires improvement



## Surgery

Good



We gave the surgical services at the Tameside General Hospital an overall rating of 'good'. This was because:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises.
- The surgical services reported one 'never event' between June 2015 and May 2016. Remedial actions such as staff training and policy updates were taken to learn from the incident. The theatre teams followed the 'five steps to safer surgery' procedures and staff adherence to was monitored through routine audits.
- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their annual appraisals and achieved with the hospital's internal targets.
- The surgical services achieved the 18 week referral to treatment standards across most specialties. Actions were taken to improve compliance in the surgical specialties where these standards had not been achieved, such as for trauma and orthopaedics.
- There were 243 elective operations cancelled on the day of surgery between July 2015 and June 2016. The most frequent reason for these cancellations was bed unavailability. There had been no non-elective (emergency) surgery

# Summary of findings

operations during this period. The services also performed better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.

- The theatre service improvement project included actions to improve efficiency and minimise patient delays. Measures such as the 'golden patient' had led to improvements in the number of theatre lists starting on time. The hospital had also launched 'Home First' initiative, which aimed to reduce bed occupancy by supporting suitable patients to receive care in their own place of residence.
- There were systems in place to support vulnerable patients. Staff applied 'reasonable adjustment' principles for patients with learning disabilities and care plans were in place to instruct staff on how to care for patients with learning disabilities.
- Patients and their relatives spoke positively about the care and treatment they received. They told us they were kept fully involved in their care and the staff supported them with their emotional and spiritual needs. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- The hospital's values and objectives had been cascaded across the surgical services. Key risks to the services, audit findings and performance was monitored through routine departmental and divisional governance and quality and safety meetings.
- The staffing levels and skills mix was sufficient to meet patients' needs. Most staff had completed their annual appraisals and mandatory training. However, the mandatory training completion rate was below the hospital's internal target.
- There was effective teamwork and visible leadership across the services. Staff were positive about the culture within the surgical

# Summary of findings

services and the level of support they received from their managers. Complaints were resolved in a timely manner and shared with staff to aid learning.

## Critical care

Good



We have rated critical care services as “good” overall. This is because;

- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients.
- We found a culture where incident reporting and learning was embedded and used by staff.
- Care was delivered in line with evidence- based, best practice guidance.
- There was strong clinical and managerial leadership at unit and divisional level.
- There was an effective governance structure in place.
- Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

However,

- The data showed there was an issue with comparatively high numbers of out of hours discharges when compared with similar units.

## Maternity and gynaecology

Good



Maternity and Gynaecology were good at the Tameside General Hospital with some elements that required improvement. This is because:

- There was a system in place to investigate incidents and disseminate the lessons learnt.
- The necessary equipment was available, and had been checked in line with the trust’s policy.
- There was a robust support system in place for patients with complex emotional, mental health or drug and alcohol problems.
- Staffing levels were appropriate to meet the needs of the patients in both maternity and gynaecology services.
- The consultant cover met the guidance for the number of births in the unit.
- The maternity service took part in national audits and there was a programme of local audits. Where actions were identified these were put in place and re-audits took place.

# Summary of findings

- Local audits for practices within the gynaecology and termination of pregnancy service had been completed.
- Consent for procedures in the maternity, gynaecology and termination of pregnancy services was accurately and clearly documented.
- We observed calm, patient, friendly and professional interactions between staff and patients in all areas of women's health.
- The termination of pregnancy service was run to ensure patients could have additional support following their procedure should they need it.
- The triage area of the maternity unit ensured patients could obtain prompt telephone advice and be seen in a timely manner.
- Systems were in place to learn from complaints.
- There was a clear vision and strategy for the service, which incorporated regional and national developments.
- Staff were complimentary about the leadership of the service saying they had approachable, visible and knowledgeable managers.

## However,

- There were infection prevention and control concerns on ward 27. These were brought to the attention of the managers during the inspection and at the unannounced inspection, improvements had been made with plans for further actions.
- Emergency medicines were not safely stored in the obstetric theatre.
- Records were not securely held in the maternity and gynaecology wards.
- Mandatory training, including safeguarding training was not up to date in maternity services.
- Assessments to identify a deteriorating patient were not accurately completed on the maternity unit or the gynaecology unit.
- The safer surgery checklists were not fully completed for maternity surgical procedures.



# Summary of findings

- We saw evidence that incidents were being reported and that information following clinical incidents was fed back to staff.
- Cleanliness and hygiene was of a good standard and staff followed good practice guidance in relation to the control and prevention of infection.
- Staff were aware of their roles and responsibilities with regard to safeguarding and knew how to raise matters of concern appropriately.
- The service used national guidelines to determine care and treatment and there were a number of evidence-based pathways in place.
- Care was provided by committed, compassionate staff who were enthusiastic about their role. Parents felt confident about leaving their baby in the neonatal unit.
- The Community Children's Nursing team (CCNT) provided intervention to help avoid hospital admission, reduce the time children spent in hospital and prevent readmissions.
- Quality and performance were monitored through paediatric and divisional dashboards.
- The children's unit had won the Nursing Times Student Placement of the Year award for 2016.
- Safety testing for equipment was in place however we observed two ventilators that had not been serviced since 2013 and six breast pumps that had been due for servicing in 2014 on the neonatal unit. We reviewed this equipment on our unannounced visit and noted that servicing had taken place.
- Of the nine band 6 and 7 paediatric nurses on the children's unit, all had completed Advanced Paediatric Life Support (APLS) with the exception of two new staff, however only three were up to date at the time of our inspection. Plans were in place for three staff to attend a course in September 2016 and three in January 2017. Risk was mitigated by the on-site presence of a paediatric registrar at all times. advanced paediatric nurse practitioners, working in the paediatric emergency department had also completed APLS.

# Summary of findings

## End of life care

Good



We rated end of life care services as 'good' overall, because:

- Care and treatment was provided safely to patients at the end of life. Infection control and prevention was embedded in the service. The environment from the wards to the bereavement centre and the mortuary was appropriate for the services provided. Staff were trained appropriately and used suitable tools and observations to identify and respond to patients who were deteriorating. Anticipatory medication for end of life was prescribed in line with the trust's policies. There had been no serious incidents relating to end of life care.
- The palliative clinical nurse specialist team and complex discharge team provided a seven-day service. The HSPC team were available Monday to Friday. The mortuary team were on-call to attend out of hours. The end of life care provided was in line with evidence based professional guidelines, and work was ongoing to improve the services provided following the end of life care audit. The HSPC team, the end of life facilitator and the mortuary manager were integral in developing and delivering additional training to nursing and medical staff throughout the trust in end of life care and care after death. There was effective and collaborative multidisciplinary working.
- All staff involved in end of life care were passionate about, and delivered, compassionate care and supported patients and their relatives emotional, and spiritual, needs. Patients and relatives spoke positively about the care and information that had been provided to them. The same level of caring, sensitivity and respect was evident in the care after death provided by the bereavement and mortuary teams.
- Arrangements were in place for the rapid or fast discharge of end of life patients to their preferred place of care, which included transfer to hospice within two hours. The trust was able to carry out

# Summary of findings

post mortem scans where requested, and authorised by the coroner, which responded to the funerary needs of faiths other than the Christian belief.

- End of life care services were represented on the trust's board by a non-executive director. The end of life strategy fed into the division's wider strategy, including national and regional healthcare developments. There was a clear reporting structure in place; the leaders were visible, approachable and supported staff. The service engaged the local public in the Dying Matters campaign and were working closely with local students to develop the memory tree and garden for the bereavement centre.

However,

- The service had more work to do to further encourage and increase the use of individual plans of care that take into account end of life care patients' individual needs and those of their families, and to meet its internal key performance indicator on this. There was inconsistency in the quality and completion of do not attempt resuscitation (DNACPR) forms in some parts of the hospital, and some information within the wards' end of life link nurse files were out of date. Although there had been a small increase in the proportion of people dying in their preferred place of care, this remained lower (worse) than the regional or national average. The proportion of patients, for whom rapid or fast discharge had been requested, that were discharged within the defined timescales was low.

## Outpatients and diagnostic imaging

Good



We rated outpatients and diagnostic imaging services as good overall. This was because:

- Staff were confident about raising incidents and there were systems in place for feedback and learning from incidents and complaints. The trust had strong arrangements in place to ensure that Duty of Candour was applied accordingly, in accordance with the Health and Social Care Act 2008 and that patients received an apology, full explanation and were supported going forward.

# Summary of findings

- Staffing levels were appropriate to meet patient needs although increased demand on radiology services meant that some reporting on diagnostic imaging was outsourced overnight. There was ongoing forward planning on future staffing requirements.
- There were appropriate protocols for safeguarding adults and children and staff followed safety procedures to keep patients safe.
- Equipment was maintained and the environment was clean with steps being taken to minimise infection risks.
- The trust reacted to new guidance and procedures accordingly and were proactive in looking at successful evidence-based care and treatment in other trusts to drive improvements. Audit outcomes were discussed with staff to seek solutions and improve.
- Services were delivered by caring, committed and compassionate staff who treated people with dignity and respect.
- The trust had made huge improvements in Referral to Treatment (RTT) times and was actively seeking improvements all the time to ensure that all clinical pathways met England standards.
- There was a clear vision and strategy in place for improving the outpatients and diagnostic imaging services with identified problems, proposed solutions, clear targets, future performance measurements and achievements to date.
- We saw a number of innovative practices to improve services and patient experiences and the trust sought potential solutions by researching with an outward vision and with a mind for minimum disruption to patients.

## However,

- The trust had staffing shortfalls in radiologists and were having difficulty in recruiting new staff due to a national shortfall. They were reliant on locum coverage to meet safe staffing levels.



# Tameside General Hospital

## Detailed findings

### Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

# Detailed findings

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## Background to Tameside General Hospital

Tameside General Hospital is part of Tameside and Glossop Integrated Care 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 538 beds and employs approximately 3,400 members of staff. In 2015/16, the trust had 52,475 admissions (23,908 inpatients and 28,567 day-case admissions), 310,068 outpatient attendances and 84,264 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
- Maternity and gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostic services

## Our inspection team

Our inspection team was led by:

Chair: **Professor Iqbal Singh OBE FRCP, is a consultant in medicine for the elderly.**

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, eight CQC inspectors, two CQC assistant inspectors, a CQC analyst, a CQC inspection planner and a variety of specialists

including: An emergency nurse practitioner specialising in urgent care, a consultant physician, a matron in the medical investigations and respiratory care, a consultant in general & vascular surgery, a critical care doctor, a risk midwife, a consultant paediatrician, a clinical nurse specialist in palliative care, a consultant in palliative medicine, an imaging general manager and lead radiographer, a senior quality and risk manager and an expert by experience.

## 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

# Detailed findings

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, NHS Improvement, 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 8, 9, 10 and 11 August 2016. 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 8.30pm on 18 August 2016.

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 and Glossop Integrated Care NHS Foundation Trust was established on 1 February 2008. Previously, the trust had operated as Tameside and Glossop Acute Services NHS Trust since 1994.

- The Trust operates from the Tameside General Hospital site, which is situated in Ashton-under-Lyne. Tameside is ranked 42nd most deprived LA (out of 326) in the country.
- 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.
- Around 9% of the population in Tameside is BME, compared to 14.5% of the population in England.

- 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.

There are inpatient 528 beds - 316 General and acute - 40 Maternity

- 9 Critical care

The trust employs approximately 3,400 staff: - 256 Medical  
- 1,129 Nursing

- 2,014 Other

In 2015-16 there were 52,475 admissions (23,908 inpatients and 28,567 day-cases admissions) inpatient admissions, 310,068 outpatient (total attendances)

84,264 Accident & Emergency attendances

## Our ratings for this hospital

Our ratings for this hospital are:







# Detailed findings

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

## Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic imaging.

# Urgent and emergency services

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

## Information about the service

As part of our inspection, we visited the urgent and emergency care services at the Tameside General Hospital during our announced inspection between 8 and 10 August 2016 as part of a comprehensive inspection. We spoke with patients and relatives, observed care and treatment and reviewed 28 patient records, including observation charts, medication charts and full care records. We spoke with a range of staff at different grades including nurses, doctors, health care assistants, reception staff, ambulance staff, senior managers and matrons.

The emergency department at the Tameside General Hospital was open 24 hours a day seven days a week, providing emergency and urgent care and treatment for adults and a small number of children across the central Tameside and Glossop area.

The department consisted of a large waiting area, two triage rooms, two 'see and treat' rooms which were used to see patients with minor injuries and a further eight minor injury cubicles. The department also had a designated ambulance triage room, which was screened and private. In the majors area of the department there were 12 cubicles used to accommodate patients with more serious condition and there was two isolation cubicles used to accommodate patients with infections and one room, which had been specially adapted for patients with mental health issues. There was also a five bedded resuscitation area, which had one designated

paediatric bay, used to treat patients who were very unwell. This area led into a viewing room where patient's relatives could spend time with patients who had passed away.

The emergency department saw approximately 84,770 patients between April 2015 and April 2016. Approximately 24.8% of patients were admitted to hospital during this period. Of these 84,770 patients 18,290 (21%) were between the ages of 0-16. There was a separate paediatric area within the department with a self-contained waiting room separated from the main waiting area.

We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed performance information about the trust. We spoke with 15 staff of all grades and 12 patients who were receiving care in the emergency department.

# Urgent and emergency services

## Summary of findings

We found that patients accessing the emergency department were receiving a good service overall because:

- The emergency department was well led and staff were aware of the trust's vision and values.
- We found that there were robust governance frameworks in place and risks were appropriately identified and monitored.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- There was an open culture in the department, with areas of innovation.
- Staff were able to report incidents and were knowledgeable about the types of incident they should report.
- We saw evidence that learning from incidents and complaints was routine and this learning was disseminated.
- Infection control was effectively managed and the department was visibly clean.
- Nurse and medical staffing was sufficient to meet patient's needs.
- Patients accessing the emergency department received effective care and treatment that followed national clinical guidelines and was tailored to their individual needs.
- This care was delivered by competent and professional staff.
- The department participated in local and national audits.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff were knowledgeable about the Mental Health Act and considered this where relevant.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke very positively about the way staff treated them.
- The emergency department planned its services to meet the individual needs of the local population it served.

- There were a number of services provided by the department to ensure that patients received care which met their individual needs, including a tailored alcohol liaison and support initiative, which had won national awards.

However

- Mandatory training uptake levels were low for some subjects.
- Patients experienced delays in accessing the service due to pressures on the department.
- The trust saw less than 95% of patients within four hours of arrival for seven out of 12 months we reviewed. However, the staff and senior management team in the department worked collaboratively to manage increased pressure and had effective measures in place to ensure patients received high quality care.

# Urgent and emergency services

## Are urgent and emergency services safe?

Good



We rated urgent care services as good in relation to the safe domain because:

- Staff were aware of how to report incidents and feedback from incidents was provided.
- There was a low rate of serious incidents in the service and the service had reported no never events.
- Lessons were learned from incidents and were distributed to facilitate learning.
- Safety performance was monitored and safety thermometer data showed that rates of avoidable harm were within national averages.
- Staff were aware of how to raise and manage safeguarding issues.
- Infection rates were low and staff observed appropriate measures to protect patients from avoidable infections.
- The environment was suitable for the delivery of patient care and equipment was well maintained.
- Staff managed medicines well and completed patient records correctly, in legible handwriting in most cases.
- Nurse staffing levels were sufficient to ensure safe patient care and senior managers had plans in place to fill existing vacancies.
- Medical staffing and skill mix was sufficient to ensure safe patient care.
- We observed that staff responded appropriately and had a good awareness of their roles when a major incident occurred during the inspection.

However:

- Risk assessments designed to assess patient's risk of falls were not always completed.
- Mandatory training uptake levels were low for some subjects.
- We found that some equipment and guidelines for major incident processes were out of date. However, this was rectified immediately.

### Incidents

- All staff had access to the trust wide electronic incident reporting system. Staff were able to demonstrate how they would report an incident using this system.

- Managers reviewed all incidents and we saw evidence that appropriate responsive actions were taken as a result of incidents.
- Staff told us they received meaningful feedback relating to any incidents they raised. This feedback included what action had been taken.
- Staff were aware of the types of incident they should report and were able to give us recent examples where they had raised incident reports.
- Staff reported 533 incidents in the emergency department between 1 January 2016 and 1 May 2016, 30 of these incidents were reported in relation to the paediatric area of the department. Of these 533 incidents, 522 were categorised as low or no harm and all 30 incidents reported for the paediatric area were categorised as no harm. The highest category of incidents were in relation to the identification of pressure ulcers when a patient presented to the department. Of the 533 incidents 10 were categorised as being moderate severity and one incident was categorised as being major in severity. When an incident was categorised as moderate or major these were reviewed and investigated robustly by senior staff within the department and the governance team who played an active role in managing and learning from incidents. We saw evidence of this in the one incident investigation report we reviewed.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). One serious incident was reported to STEIS between June 2015 and May 2016. This incident related to a pressure ulcer developing while in the emergency department. Serious incidents were investigated using a root cause analysis approach. We reviewed this one investigation report which showed that a robust investigation had been undertaken and that actions had been identified and put in place to prevent reoccurrence. We also saw evidence that the service had exercised its duty of candour in serious incident investigations.
- We saw evidence in these reports that staff at all levels were involved in the investigation process for all incidents including serious incidents. Staff told us they felt positively about being involved in the root cause analysis investigation process and they felt the process was constructive not punitive.
- Managers shared lessons learned from incidents with frontline staff through individual feedback, communications on notice boards and staff meetings.

# Urgent and emergency services

The department also had an active practice development team and lead who organised teaching sessions on a variety of subjects including subjects highlighted through incident reviews. This team also worked on a one to one basis with staff to learn from incidents.

- Staff were aware of duty of candour which is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff gave examples of occasions when they had told patients something had not gone as planned and explained how they would exercise the duty of candour.

## Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- The emergency department were recording and monitoring data in line with this initiative. Information on performance in relation to this initiative was discussed at managerial and staff meetings. We reviewed information for 12 months prior to the inspection and this showed that the department performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers.

## Mandatory training

- Mandatory training compliance was reviewed regularly by the practice development lead and the managerial staff within the department and division.
- Uptake levels for most mandatory training subjects were variable between subjects with some areas of high uptake, which met the trust's target, and some areas of low uptake, which did not meet the trust's target.
- There were nine subjects which staff were required to undertake mandatory training in, some subjects required that they were undertaken on a yearly basis and others on a two yearly basis. Uptake levels for information governance were higher than the trust's

target at 99%. However, the level for infection control and prevention for nurses and doctors was lower than the trust's target at 89%. The rates of uptake for resuscitation training were lower than the trust's target at 92%. When we reviewed local records for staff within the department who required advanced life support, advanced trauma life support and advanced paediatric life support, we found that all these staff were current and up to date with their training in these subjects.

- This issue had been identified by the managers within the department and the practice development lead had taken steps to address these areas of low uptake. We observed that the practice development lead had actions in place to address these issues. Their records showed that there had been a significant improvement in the rates of mandatory training compliance in the months prior to the inspection. This issue was also being monitored by the department's matron, divisional lead nurse and divisional director.
- Staff told us they were encouraged to attend mandatory training and the practice development lead and their manager reminded them when their mandatory training was due for renewal.

## Safeguarding

- The trust had safeguarding policies and procedures in place, which were readily available on the trust's intranet site.
- Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- The trust had an internal safeguarding team who could provide guidance and support to staff in all areas. This team were easily accessible by telephone and email. During out of hours period's staff had access to senior nursing staff within the hospital management team to seek advice and guidance on safeguarding issues.
- The lead nurse for the paediatric area of the department reviewed all paediatric attendances to check for any issues of a safeguarding nature.
- The emergency department records contained a safeguarding trigger area to prompt staff to consider safeguarding issues.
- The uptake for level two safeguarding vulnerable adults training was high at 98.5% for nursing and medical staff. Safeguarding training provides staff with the knowledge and skills necessary to identify patients who are at risk of harm and abuse.



# Urgent and emergency services

- The uptake levels for mandatory safeguarding children training were lower than the trust's target of 95% at 80% for nursing staff and 75% for medical staff.
- Staff were able to explain the application of the law and their responsibilities in relation to female genital mutilation. There was also clear guidance available in the emergency department in relation to this subject.
- Staff were knowledgeable about child exploitation and trafficking and considered this as part of their patient assessments.
- Staff told us they received feedback from all safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff and their managers.

## Cleanliness, infection control and hygiene

- The department effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections.
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections identified in the year prior to the inspection.
- All areas of the department were visibly clean and well maintained.
- Staff were aware of current infection prevention and control guidelines and were able to give us examples of how they would apply these principles.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons, and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance.
- Patients with an infection were isolated in side rooms, where possible. Staff identified the rooms with signs and information about control measures were clearly displayed.
- All areas, which were used to accommodate patients with an infection, were appropriately cleaned at the level stipulated in the trust's infection control processes. This included deep cleaning of areas when these areas had been exposed to certain groups of infections.

- We observed that cubicles and trolley spaces were cleaned between uses including during busy periods.

## Environment and equipment

- Equipment in all areas of the department was visibly clean and well maintained.
- Staff told us they had easy access to the equipment they needed to care for patients.
- Records indicated that staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was in place and records indicated it had been checked daily, with a more detailed check carried out weekly as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Bariatric equipment used for obese patients was readily available.
- Appropriate equipment was available for paediatric patients including all equipment, which could be required specifically for children.
- Resuscitation trolleys were secured with a tamper evident tag system.
- The admission route for patients was set up so patients arriving by ambulance were seen and triaged in a designated bay area by designated staff.
- There was an x-ray department situated next to the unit for easy access, which also provided portable x-rays.
- Portable appliance testing (routine testing of electronic devices) was up to date for all electrical equipment we reviewed.
- Security staff were available on site 24 hours a day and were able to be contacted by telephone, if required.

## Medicines

- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. There were appropriate arrangements in place for the destruction of unwanted and expired medicines. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy.
- Emergency medicines and equipment were readily available and there was a procedure in place to ensure they were fit for use.
- Medicines fridges were secured, however maximum and minimum temperatures had not been recorded in accordance with national guidance. We checked fridge

# Urgent and emergency services

thermometers and found maximum and minimum temperatures outside of the recommended range for storing medicines; it was unclear whether staff had reset thermometers correctly. In addition, we saw temperatures outside of the recommended range had been recorded in majors and no record had been made of the action taken, which was not in accordance with trust policy. Therefore, we could not be sure medicines stored in this fridge were fit for use.

- Patient Group Directions (PGDs) were in use to support patient access to medicines in a timely way, and there was a procedure in place to manage and review them. PGDs are written instructions, which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription.
- Controlled drugs were stored appropriately in locked cupboards in line with legislation on the management of controlled drugs. Records showed these medications were checked on a daily basis. Controlled drugs require additional checks and special storage arrangements because of their potential for abuse or addiction and also require clear and precise documentation of any wastage.
- There were appropriate processes in place for ordering medications and stock reconciliation and a designated pharmacist assisted the department with this. Staff also had 24 hour access to pharmacy support, if required.
- We observed nurses administering medications to patients and they undertook appropriate checks including checking the patient's name, date of birth and allergy status.
- Discharge medications and prescriptions were managed well. Prescriptions for these medications were completed legibly and records for take home medications were amended accordingly. Discharge notifications were provided to patients and to their GPs, where appropriate.
- Guidelines on the use and preparation of medication were readily available including specific guidelines for children.

## Records

- The department used paper based patient records and some electronic records. Records were stored in trolleys, which were not locked but were not easily accessible to members of the public.

- We reviewed 28 patients' records during our visit and found that records relating to patient treatment were legible and easy to follow. We found that patients' nursing records were kept up to date and fully completed.
- Senior sisters told us that they audited nursing records on an ad hoc basis and highlighted any areas of improvement to staff immediately.
- Record keeping was listed on the emergency department yearly audit plan and this audit was undertaken on a quarterly basis.

## Assessing and responding to patient risk

- Patients who self-presented to the department were seen by a receptionist and were booked in and directed to the waiting room where they were triaged by a designated nurse.
- Patients arriving by ambulance were alerted to the ambulance triage area nurse and triaged in a designated ambulance triage room.
- The trust used a recognised triage system for the initial assessment of all patients. Triage ensures that patients are directed to the appropriate part of the department and seen in a specified time frame decided by their clinical condition. Serious life-threatening conditions are also identified or ruled out so that the appropriate care pathway can be commenced without delay.
- The Royal College of Emergency Medicine (CEM) recommends that a face to face assessment of patients should be carried out by a clinician within 15 minutes of arrival or registration. We found that all patients we reviewed had a face to face assessment within 15 minutes of their arrival. The median time to initial assessment for patients presenting to the department by ambulance between February 2015 and February 2016 was consistently higher than the England average for all months by approximately two to three minutes. This meant that patients waited on average two to three minutes more for their initial assessment in this trust than in others across England.
- There were 211 black breaches from May 2015 and May 2016. Black breaches occur when the time from an ambulance's arrival to the patient being allocated a space and being handed over to the department staff is greater than 60 minutes. Most of these breaches occurred during the winter months when the department was under additional pressure. The service had implemented a system by where all patients

# Urgent and emergency services

arriving by ambulance were seen immediately on arrival by a member of nursing staff and assessed prior to being allocated a space in the department. At this assessment, observations and an assessment of the patients' clinical condition would be made to establish whether they required immediate intervention.

- The median time to treatment time was consistently higher than the England average for this same time period. However, the service was working on innovative ways to improve access and flow.
- An early warning score (EWS) system was in use in the department. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly.
- We reviewed one patient with a diagnosis of sepsis. This patient received timely care and treatment in line with the sepsis pathway. The trust had designated sepsis nurses who would attend the department to assist with the management of patients with sepsis.
- We observed that patients were accommodated in an appropriate area of the department and not in the main corridor areas during all three days of our visit.
- On admission, staff were required to carry out risk assessments to identify patients at risk of specific harm such as pressure ulcers, self-harm and risk of falls. If staff identified patients susceptible to these risks, staff were required to place patients on the relevant care pathway and treatment plans. We found that, patients were placed on the pathway which related to the risks identified including self-harm and pressure care.
- We observed three patients who were admitted who were at risk of developing pressure ulcers. All three of these patients had the appropriate risk assessment section of their records completed and there was evidence that staff had taken appropriate action to mitigate this risk.

## Nursing staffing

- The staffing levels expected on a daytime shift for the department were 11 registered nurses and four health care assistants. At night time, this was reduced by one staff nurse and one health care assistant.
- The staffing in the department was sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. Regular

staffing meetings were held and senior managers were observed frequently attending the department to assess staffing levels and patient acuity. Managers made attempts to reduce the risks associated with using bank and agency staff by ensuring these staff were mixed with permanent staff members.

- We reviewed two months of rotas, which showed staffing levels were within recommended guidelines for most shifts. On the shifts where the staffing figures fell below the recommended guidelines; this was due to short term and last minute absence. Managers had responded appropriately to try to address these staffing deficits.
- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty.
- The department openly displayed the expected and actual staffing levels on a notice board and staff updated them on a daily basis. The staffing numbers displayed on the boards were correct at the time of the inspection and reflected the actual staffing numbers in all areas.
- We observed one nursing staff handover, which was comprehensive and well structured. Safety information was handed over as part of this so that staff were aware of any issues, which could affect patient safety.
- At the time of the inspection, there were five nursing vacancies within the emergency department. Senior managers within the department were actively recruiting into these posts.
- The turnover rate for nursing staff within the department was 14%. This means that in one year 14% of the nursing employees moved on and were replaced by a new employee. This was higher than the trust's average turnover rate of 9%. A lower turnover rate indicates stability in the workforce and means that key skills and experience remain within a department.
- Sickness rates for nursing staff working in the department were higher than the national average of approximately 4% at 7.85%.
- The department completed a yearly nurse staffing audit using a recognised workforce planning tool. The tool calculated the workforce and skill mix required to provide the nursing care needed in the department during the audit period.

## Medical staffing

# Urgent and emergency services

- The medical staffing skill mix was sufficient when compared with the England average. Consultants made up 27% of the medical workforce in the department, which was 1% better than the England average of 26%. However, there were significantly less registrar group doctors who made up 23% of the medical workforce compared with the England average of 39%. However, the department did have more middle grade doctors at 27% to fill this gap. This was better than the England average of 13%. An additional 23% of the medical workforce were made up of junior doctors, which was the same as the England average of 23%.
- Consultants worked on a rota basis to provide cover seven days a week. Their shifts ran from either 8am until 12pm or 12pm to 8am. The most senior doctor on duty would be a registrar grade doctor (very experienced senior doctor). Consultant cover after 12am was available on an on call basis. However, there were two senior middle grade doctors present in the department between 12am and 8am.
- Junior and registrar grade doctors told us they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed.
- Nursing staff told us that they were able to access medical assistance and advice easily.
- We saw evidence that patients were seen promptly by medical staff if flagged up by the nurse following triage and also when additional reviews were requested by nursing staff.

## Major incident awareness and training

- The trust had a major incident policy in place, which was available on the trust intranet site. Staff were able to tell us how they would access this policy and showed a good understanding of the policy.
- The department had a designated major incident cupboard which contained all the relevant equipment, grab bags, action cards and policies staff may require in the event of a major incident. When we inspected this cupboard on the first day of the inspection, we found a number of pieces of equipment were past their expiry date and that the action cards in the cupboard were also out of date. We highlighted this to the department manager who rectified the issue immediately. We also found that up to date action cards and equipment were

readily available within the department itself. These action cards to guide staff on what to do during a major incident were easy to follow and fit for purpose detailing roles and responsibilities.

- During the inspection, the department was a primary receiver for casualties from a major incident in the local area. We observed that staff were calm and composed and followed the trust's major incident policy at all stages. We observed the appropriate triage and receiving of casualties into the department and staff liaising with other organisations to coordinate their approach to the incident.
- Following on from the incident we observed that a formal debrief session was held quickly and led by a senior manager. Staff engaged with this debrief and expressed that they felt the incident had been dealt with appropriately.
- Staff received major incident training including participation in simulated training exercises.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- The department was in the process of opening a designated HAZMAT building adjacent to the department. This building was commissioned to ensure that patients received the best possible care when presenting with contamination by hazardous materials. It also afforded patients a higher level of privacy and dignity as opposed to the department's previous arrangements, which were the use of a tent.
- There was a designated folder on major incident procedures available in the staff offices in the department.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated urgent care services as 'good' for effective because:

# Urgent and emergency services

- Patients accessing the emergency department received effective care and treatment that followed national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM).
- The department participated in local and national CEM audits. Action plans were formulated following audits and progress on these actions were monitored. Evidence based pathways were used and staff placed patients on these pathways as soon as possible.
- The trust's policies and procedures reflected national guidelines and best practice.
- Patients' nutritional and hydration needs were identified and addressed appropriately.
- Patients received timely analgesia when they required it.
- Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff were knowledgeable about the Mental Health Act and considered this, where relevant.

However,

- Data from national surveys showed that patients treated within the department had outcomes, which were in some cases worse than patients treated in other trusts in England.
- Some staff had not received their annual appraisal.

## **Evidence based care and treatment**

- The emergency department used both National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to guide the care and treatment they provided to patients.
- A range of evidence based clinical care pathways were available and were put in place for patients with relevant conditions. These included fracture neck of femur, sepsis, stroke and overdose. These pathways included prompts and treatment steps for staff to follow. Patients were placed on appropriate pathways as soon as their condition was diagnosed which ensured that they received timely and appropriate interventions. The pathways were regularly reviewed on a trust wide basis and reflected current guidance from the National Institute for Health and Care Excellence (NICE).

- Policies and procedures reflected current national guidelines and were easily accessible electronically and also in paper form in the department.
- We observed that patients were placed on these pathways when appropriate. One example of this was a patient who presented with acute chest pain, who was placed on the appropriate pathway for this symptom. We observed that this patient received care and treatment in line with national guidelines including undergoing specific tests at specific time points.

## **Nutrition and hydration**

- The trust scored worse than other trusts of a similar size in England for the one question related to nutrition and hydration in the Accident and Emergency (A&E) survey 2014.
- However all patients we spoke with did not raise any concerns about the provision of food and drink within the department. We asked four patients who had been in the departments longer than four hours whether they had been offered food and drink and they all confirmed that they had.
- The department had facilities for making drinks and food, including sandwiches, was available if needed.
- Staff identified patients who were not able to eat and drink and assistance was provided as they required. We observed staff helping two patients to eat their meals. Staff spoke with the patients to obtain their consent and treated them sensitively during their meal.
- We identified four patients who required their fluid balance recording and in all four of these cases the fluid balance charts were completed appropriately.
- We also found evidence in patient records that malnutrition risk assessments were completed appropriately in cases where patients were at risk of malnourishment.

## **Pain relief**

- The department scored about the same as others of a similar size in England for one of the two questions in the A&E survey, 2014 relating to pain relief and worse than other trust of a similar size in England for the other question.
- We observed that pain relief was routinely offered on triage to walk in patients experiencing pain.
- In all records we reviewed, which indicated patients required analgesia, this was prescribed appropriately.



# Urgent and emergency services

- We asked five patients who had presented with conditions that may have caused pain whether their pain was managed appropriately. All five patients told us that they had received adequate pain relief.
- We observed that pain scores were routinely recorded on triage and throughout the patient's journey in the department. We also observed that pain relief commensurate to the level of pain were experiencing was prescribed and administered. We observed an example of this in a patient who was experiencing increasing pain over the period of an hour, staff returned to the patient approximately every 15 minutes to assess their response to the analgesia. After 30 minutes the patient had not experienced a significant reduction in their pain level. Staff ensured that the patient was reviewed and a doctor prescribed a stronger form of analgesia, which was immediately administered to the patient to good effect.

## Patient outcomes

- The department participated in local audits regularly and provided evidence of improvements to patients' care as a result of these audits.
- The department participated in the national Royal College of Emergency Medicine (CEM) audits. CEM audits allow trusts to benchmark their practice against national best practice and encourage improvements.
- The department participated in the consultant sign off audit, 2013. The department scored about the same or better than other trusts in England for two of the four standards in this audit. The department scored worse than other trusts in England for two of the four standards. These standards were both relating to the discussions held with patients about their treatment. The department had an action plan in place to address these areas of improvement. We also spoke with three patients about whether they had spoken with a doctor and whether they felt informed about their care. All three patients told us that they felt they had been given enough information by the doctors looking after them.
- The department participated in the national Royal College of Emergency Medicine (CEM) 2013/14 severe sepsis and septic shock audit. The department scored about the same or better than other trusts in England for nine out of 12 standards. The department scored worse than other trusts in England for three out of nine standards. These standards related to the obtaining of a specific blood test, documentation of blood tests in

patients notes and antibiotic administration. The department had an action plan in place to address this and were auditing their performance in relation to sepsis locally. The trust had appointed a sepsis nurse since this audit and had also introduced a robust pathway for patients presenting with signs of sepsis, which met national guidelines. We reviewed the records of one patient who had presented with sepsis. We found that this patient was treated in accordance with national guidelines and also in line with the trust's pathway for sepsis.

- The department also participated in the national Royal College of Emergency Medicine (CEM) 2013/14 asthma in children audit. Results showed that the trust scored about the same or better than other trusts in England for seven out of 10 standards. They performed worse than other trusts for three out of ten standards. These standards related to the documentation of a consciousness score, peak flow measurements and the administration of a specific medication. The department had an action plan in place to address these issues. We also observed that there were clear guidelines available for medical and nursing staff to follow when treating a child presenting with asthma related problems.
- The department participated in the national Royal College of Emergency Medicine (CEM) 2013/14 paracetamol overdose audit. Results from this audit showed that the trust performed better than other trusts in England for three out of the four standards and the same as other trusts for one out of four standards.
- The department participated in the national Royal College of Emergency Medicine (CEM) 2014/15 audit looking at the initial management of the fitting child. The department scored about the same as other trusts for three out of five standards and worse than other trusts for two out of five standards. These standards related to the recording of eye witness history and the provision of safety information to parents on discharge. The department had an action plan in place to address these areas of improvement and were working on the development of an information leaflet to be provided to parents.
- The department participated in the national Royal College of Emergency Medicine (CEM) 2014/15 audit looking at the assessment of cognitive impairment in older people. The department scored about the same as other trusts in England for three out of four standards and worse for one out of four standards. This standard

# Urgent and emergency services

was the assessment of cognitive impairment. The clinical lead for the department told us that this was an area they were addressing through teaching with middle grade and junior doctors. We also observed an action plan in place to address this issue.

- The unplanned re-attendance rate for urgent care services within the trust within seven days was consistently better than the England average between August 2015 and February 2016 however this was still below the national standard of 5% of admissions resulting in unplanned re attendance. This meant that less patients re attended A&E in this trust than others in England. The trust had regular department and divisional level meetings where measures to reduce the re-attendance rates were discussed.

## Competent staff

- We found that 77% of nursing staff within the department had received their annual appraisal. However, this was significant improvement on the last appraisal data capture which showed that on 43% of staff had received their annual appraisal. The managers in the department told us that they had plans in place to provide appraisals to staff who had not received an appraisal during the last financial year first in the next year. This was below the trust's target of 90%. An appraisal gives staff an opportunity to discuss their progress and any concerns or issues with their manager.
- Both nursing and medical staff were positive about learning relevant to their role and development opportunities.
- Medical and nursing staff told us clinical supervision was available and they felt adequately supported.
- New nursing staff received emergency department specific competency based training. They were supported by a mentor and were supernumerary for a period of time which varied depending on their previous experience and learning needs.
- The department had a designated practice development senior nurse. This nurse had only recently been seconded into this post with the aim of improving training and appraisal rates. This nurse showed us comprehensive plans, which she had developed to improve rates of training and appraisals. There had been a significant improvement in the rates of both nursing and medical appraisal rates since her commencement in this post.

- Agency and bank staff received a local department induction on arrival to their shifts.

## Multidisciplinary working

- We saw evidence that there was effective communication and collaboration between multidisciplinary team members within the emergency department, other specialities and external stakeholders. This included engagement with external support organisations to ensure that patients received the best possible support and care.
- Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.
- Nursing staff told us they had good relationships with consultants and doctors of different disciplines. We observed the senior consultants leading the department working closely with the nursing staff and senior managers to facilitate patient care and flow.
- Staff told us they received support from pharmacists, physiotherapists, occupational therapists, social workers and diagnostic support.
- The rapid assessment and interface discharge (RAID) team who were employed by a neighbouring trust; provided mental health services and worked closely with staff to ensure patients were supported on discharge. Staff told us that they had ready access to this team and experienced minimal delays in accessing their support. We saw examples of the department staff working with this team to facilitate the safe discharge of a patient.
- Staff working for an ambulance services told us they felt the staff in the department communicated effectively with them.

## Seven day services

- The department functioned fully 24 hours a day, seven days a week. This included the paediatric area.
- Access to radiology services was available 24 hours a day, seven days a week including CT scanning.
- Consultants provided on call cover for 24 hours, seven days a week. At least two middle grade or registrar doctors were also present in the department 24 hours each day, seven days per week.
- Staff also had 24 hour access to mental health services.

## Access to information

# Urgent and emergency services

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- The records we reviewed were easy to locate and easy to follow. This meant staff could access all the information needed about patients easily.
- Medical staff produced discharge summaries and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might require.
- We saw patients being transferred from the department to medical and surgical admission units. The information provided in these handovers was accurate and detailed, which ensured the receiving staff had all the relevant information they needed.

## Consent, Mental Capacity Act and DoLS

- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records, where appropriate.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff gave us examples of when patients lacked the capacity to make their own decisions and how this would be managed.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards during working hours. During out of hours periods staff were able to seek advice and support from the senior nurse on site.

## Are urgent and emergency services caring?

Good



We rated urgent care services as 'good' for caring because:

- Staff treated patients with kindness, dignity and respect.
- Staff provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.
- Patients told us they were involved in decisions about their care and were informed about their plans of care.
- Staff took their time to support patients and ensure they knew what was happening.
- Staff showed that they understood the importance of providing emotional support for patients and their families.
- Patients and their families told us they felt well supported and involved as partners in their care and treatment.

However,

- Data from the NHS Friends and Family Test showed that the percentage of patients who would recommend the department to their friends and family was below the England average for 12 out of 12 months between April 2015 and March 2016.
- The trust scored worse than other trust in England in the CQC A&E survey 2014 for 22 out of 24 questions.

## Compassionate care

- Data provided by the NHS friends and family test (FFT) showed that less than 88% of patients would recommend the emergency department to their friends and family for 12 out of 12 months between April 2015 and March 2016.
- The trust also scored worse than other trusts for 22 out of 24 standards related to compassionate care in the 2014 A&E survey.
- We observed staff treating patients with kindness and compassion during all interactions. Staff took time to interact with patients and treated them with dignity and respect.



# Urgent and emergency services

- We observed that curtains were closed around patient's bed areas when staff were providing care. There were private rooms available where staff could speak to patients privately, if required, in order to maintain confidentiality.
- We spoke with 12 patients, who all gave us positive feedback about how staff treated and interacted with them.
- We saw that staff interacted with patients compassionately including during busy times.
- The department had also developed a butterfly symbol, which they would place on the curtains outside the viewing area for deceased patients. This alerted other staff that patients' relatives were spending time with them in the deceased viewing area.

## Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and treated patients as partners in their care. Staff communicated with patients in a way they could understand.
- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in the form of written materials, such as discharge information leaflets specific to their condition.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.

## Emotional support

- Staff understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.
- Patients and relatives told us that staff supported them with their emotional needs.
- Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.
- Staff confirmed they could access management support or counselling services after they had been involved with a distressing event. Staff were included in debriefing sessions, which were facilitated by the practice development team following traumatic events.

- The department worked closely with a local project, which supported patients who had experienced domestic abuse. This collaboration provided in reach by the project workers to the department to provide support and safe places for patients experiencing domestic violence.

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

Requires improvement



We rated urgent care services as 'requires improvement' for responsive because:

- The department frequently experienced issues with access and flow.
- The Department of Health standard for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust failed to meet this target for 12 out of 12 months between April 2015 and March 2016. For some of these months the department failed to meet this standard by a large margin. In the winter months at times the department saw less than 75% of patients within four hours of arrival.

However,

- Complaints were well managed and evidence of action taken as a result of them was evident.
- The trust had an escalation plan in place and staff at all levels followed the steps set out in this policy.
- The staff and senior management team worked collaboratively to manage increased pressure and had effective measures in place to ensure patients received high quality care.
- The emergency department planned its services to meet the individual needs of the local population it served.
- There were a number of innovative measures, which were being undertaken to improve the flow of patients through the department.

## Service planning and delivery to meet the needs of local people

# Urgent and emergency services

- During our inspection, the department was near to full capacity on occasions. However, we observed that during these times there were sufficient trolley and cubicle spaces to accommodate patients.
- Of the patients attending the emergency department, 21.7% were under the age of 16. The department stocked all equipment required for the treatment of children in an emergency situation. The paediatric area of the department was appropriately segregated from the adult area. This area contained toys and activities for children attending the department and was staffed by nurses with either a specific paediatric qualification or additional training in the management of paediatric patients.
- The department served a deprived local area and as a result treated patients frequently with chronic conditions. As a result the department and local ambulance liaison officer had worked closely with the chronic conditions teams and nurses to provide these patients with the most appropriate care. This initiative also meant that the chronic conditions team were informed and aware when a patient receiving care from them attended the emergency department.
- We spoke with staff from ethnic minority backgrounds. All three staff told us they felt supported in their roles and had not been discriminated against in the course of their employment.

## Meeting people's individual needs

- There were adequate facilities to allow access and use by disabled patients. Including wide corridors and rails in disabled bathrooms.
- Information leaflets about services available and discharge advice were readily available in the department. Leaflets could also be provided in different languages or other formats, such as braille and audio, if requested.
- Staff told us that they could access a language interpreter if needed and were able to show us how they would do this.
- Access to psychiatric support was readily available from the rapid assessment and interface discharge (RAID) team which was provided by a neighbouring trust. There was also a designated room to accommodate patients with mental health problems. This room was painted and decorated in calming colours and was also sound

proof to minimise noise that these patients would hear as this can cause distress to patients presenting with acute mental health problems. The room also contained soft furniture to minimise the risk of self-harming.

- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).
- The department also had a strategy to help and support individuals experiencing domestic violence.
- There was a pathway for patients living with dementia, which guided staff on how best to treat and meet the needs of these patients. This pathway would follow the patient throughout their hospital journey.

## Access and flow

- There is a Department of Health standard for emergency departments to admit, transfer or discharge patients within four hours of arrival. From March 2015 to April 2016, the trust did not meet this standard. For some of these months the department failed to meet this standard by a large margin. In the winter months at times the department saw less than 75% of patients within four hours of arrival.
- From April 2015 to March 2016, the percentage of emergency admissions waiting four to 12 hours from decision to admit until being admitted was reported as being above the England average for nine out of 12 months. For three out of 12 months the percentage of people waiting four to 12 hours was lower than the England average. This means that on average patients waited more time when being admitted to hospital than in other trusts of a similar size in England.
- Strategic data showed the percentage of patients leaving before being seen was consistently worse than the England average for the 12 month period between March 2015 and April 2016. This means more patients left before being seen in this department than in other departments of a similar size across England.
- From March 2015 to April 2016, the total time patients spent in the emergency department (average per patient) was consistently worse than the England average. This meant that, on average, patients spent more time in this emergency department than at other departments of a similar size across England.
- The trust had an escalation process in place for periods when there was increased demand. The purpose of this process was to ensure the effective management of the

# Urgent and emergency services

trust's bed capacity and to give staff clear processes and triggers to follow in times of increased demand. We found that the actions set out in this process were followed when increased pressure was experienced in the emergency department.

- There were bed meetings held three times a day. These meetings were attended by senior nursing staff from the ward areas, patient flow team and the emergency department team. These meetings were well structured and provided the staff who attended with meaningful data and updates on potential inpatient bed availability.
- We observed numerous patients experiencing long waits to be seen and be allocated inpatient beds.
- There was also a designated minors streaming area, which was staffed by nurse practitioners and medical staff when required. This streaming system ensured that patients with minor injuries could be seen quickly and alleviated the pressure on the overall department.
- The department also had an adjacent clinical decisions unit. This unit was used to accommodate patients with specific conditions who were awaiting test results or a clinical decision. This unit allowed patients to be accommodated in the place best suited to their needs and alleviated the pressure within the department and freed up trolley spaces.
- The department scored about the same as other departments in England in relation to the one question in the CQC A&E survey 2014 relating to waiting times.

## Learning from complaints and concerns

- Information on how to raise a complaint and contact details of the patients advice and liaison service (PALS) team was prominently displayed around the emergency department.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient.
- The trust recorded complaints on the trust-wide system. The matron and divisional lead were responsible for investigating complaints and the divisional managers reviewed all complaints to identify themes and trends.
- We reviewed one complaint record and found that it had been appropriately documented and tracked. The complaint had been responded to in a timely manner and apologies had been offered, where appropriate.
- Information about complaints was discussed during staff meetings to facilitate learning.

## Are urgent and emergency services well-led?

Good



We rated urgent care services as 'good' for well led because:

- The trust's vision and values were embedded and staff embodied these values in their daily working lives.
- There were robust governance frameworks and managers were clear about their roles and responsibilities. Risks were appropriately identified, monitored and there was evidence of action taken, where appropriate.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- Managers were visible and staff felt able to approach them.
- Staff told us the culture within the service was open and they felt very well supported.
- There were areas of innovation and leaders within the services were working to continually improve services.

## Services vision and strategy

- The trust had a mission statement, which set out their vision this was "at Tameside General Hospital 'Everyone Matters.' Our aim is to deliver, with our partners, safe, effective and personal care, which you can trust". This mission and vision was further clarified and fed into by a set of corporate objectives which included ensuring patients received harm free care and strengthening of community services.
- The trust also had a set of values, which had been developed with input from staff and patients.
- Staff were aware of the trust vision, objectives and values. They were also able to articulate the vision and values and how these related to their day to day roles.
- The trust's values were based on five specific areas safety, care, respect, communication and learning. Under each of these areas the trust listed a set of behaviours that would embody these values. These values were prominently displayed around the hospital and also on cards carried by staff members.
- All staff were aware of these values and embodied these values in the behaviour we observed during the inspection.

# Urgent and emergency services

## Governance, risk management and quality measurement

- There was a robust governance framework within the emergency department. Senior managers were clear on their roles in relation to governance and they identified, understood and appropriately managed quality, performance and risk.
- There was a risk register in place and there was a clear alignment of risks recorded with what staff told us was concerning them. Managers regularly reviewed, updated and escalated the risks on these registers, where appropriate. There were action plans in place to address the identified risks. One example of this was the risk of a ligature point in the room used to accommodate patients with mental illness. This risk was identified a number of years ago and we observed that it had been updated annually with actions in place to mitigate the risk. These actions included health and safety assessments and weight testing.
- There was a system in place that allowed senior staff in the department to escalate risks to trust board level through various meetings.
- Audit and monitoring of key processes took place in the department to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives through performance dashboards and meetings.
- There was regular monthly clinical governance meetings held and we saw minutes from this meeting. Subjects discussed included current risks, themes and trends of incidents and recent incidents.
- There was a lead matron and doctor with a responsibility for governance and quality. They would review incidents and complaints to identify any themes and areas for improvement.

## Leadership of this services

- The leadership in the department reflected the vision and values set out by the trust. Staff spoke positively about their managers and leaders.
- Leaders were visible, respected and competent in their roles.
- There were clearly defined and visible leadership roles in the department.

- Staff identified members of the executive and senior management team and told us they were frequently in the clinical areas and spoke with staff regularly.
- Staff particularly spoke positively of the divisional lead nurse and divisional director.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required.

## Culture within this services

- There was an open, patient centred culture within the department where staff were encouraged to raise any concerns about safety.
- All staff we spoke with told us they felt respected and valued.
- All staff told us they would feel secure raising a concern or issue with their managers.

## Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The department participated in the NHS Friends and Family test, which gives people the opportunity to provide feedback about the care and treatment they received.
- The department also undertook local surveys specific to the department to gain focused feedback on their services.

## Staff engagement

- Staff participated in regular team meetings led by the department's managers.
- Staff told us they received support and regular communication from their managers in the form of emails, newsletters and individual interactions.
- All staff we spoke with told us they felt they had opportunity to discuss any developments or changes within the hospital.
- The trust also engaged with staff via newsletters and through correspondence displayed on notice boards in staff areas.





## Innovation, improvement and sustainability

- Staff and managers were continually striving to improve the care and treatment patients received.

# Urgent and emergency services

- There was a realistic and comprehensive local strategy for the department and division and the service was making good progress in relation to this.
- Staff told us they were able to suggest improvements to managers and they considered and implemented them where possible.
- The service undertook regular root cause analysis reviews of their longest waits to facilitate learning for the future.
- The service had also recently implemented a live computerised white board for the emergency department. This allowed senior staff within the trust and partner organisations to live track patients and also gave them an overview of the current situation within the department at all times.
- The department had also introduced four hourly 'board rounds'. These rounds consisted of all staff within the department gathering around the whiteboard to assess the situation within the department at that time and ensure all patients were in the correct location and were receiving the appropriate care.
- Leaders were working to continually improve services.

## Medical care

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

Information about the service

Summary of findings

# Medical care

Are medical care services safe?

Requires improvement



Good



Are medical care services effective?

Requires improvement



Good



Are medical care services caring?

Are medical care services responsive?

Good









Are medical care services well-led?

Good



# Surgery

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

## Information about the service

Tameside General Hospital provides a range of surgical services, including trauma and orthopaedics, oral surgery, ear, nose and throat (ENT), plastic surgery, urology, ophthalmology and general surgery (such as colorectal surgery).

The hospital has three surgical wards with approximately 77 inpatient surgical beds. There are 10 operating theatres that carry out emergency trauma and general surgery as well as some day case and elective surgery procedures. There is also a day case unit and an endoscopy unit located in the hospital.

There were 16,436 surgical procedures carried out at the hospital between March 2015 and February 2016 and 65% of patients had day surgery, 15% had elective surgery and 20% were emergency surgical patients.

We visited Tameside General Hospital as part of our announced inspection during 8 to 11 August 2016. We also carried out an out-of-hours unannounced visit on 18 August 2016. As part of the inspection, we visited the theatres, the endoscopy unit, the day case unit, the surgical unit, the planned orthopaedic unit (POU) and the emergency orthopaedic unit (EOU).

We spoke with 12 patients and the relatives of another four patients. We observed care and treatment and looked at 16 care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, anaesthetists, ward managers, the practice educator, healthcare assistants, the matrons for surgery and theatres, theatres staff, the divisional governance lead, the

director manager, the booking team leader, the endoscopy unit manager, the divisional director of operations and the clinical director for surgery. We received comments from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.



# Surgery

## Summary of findings

We gave the surgical services at the Tameside General Hospital an overall rating of 'good'. This was because:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises.
- The surgical services reported one 'never event' between June 2015 and May 2016. Remedial actions such as staff training and policy updates were taken to learn from the incident. The theatre teams followed the 'five steps to safer surgery' procedures and staff adherence to was monitored through routine audits.
- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their annual appraisals and achieved with the hospital's internal targets.
- The surgical services performed better than the national average for 18 week referral to treatment waiting times across most specialties. Actions were taken to improve compliance in the surgical specialties where this had not been achieved, such as for trauma and orthopaedics.
- There had been no non-elective (emergency) surgery operations between July 2015 and June 2016. The services also performed better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.
- The theatre service improvement project included actions to improve efficiency and minimise patient delays. Measures such as the 'golden patient' had led to improvements in the number of theatre lists starting on time.

- There were systems in place to support vulnerable patients. Staff applied 'reasonable adjustment' principles for patients with learning disabilities and care plans were in place to instruct staff on how to care for patients with learning disabilities.
- Patients and their relatives spoke positively about the care and treatment they received. They told us they were kept fully involved in their care and the staff supported them with their emotional and spiritual needs. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- The hospital's values and objectives had been cascaded across the surgical services. Key risks to the services, audit findings and performance was monitored through routine departmental and divisional governance and quality and safety meetings.
- The staffing levels and skills mix was sufficient to meet patients' needs. Most staff had completed their annual appraisals and mandatory training; however the mandatory training completion rate was below the hospital's internal target.
- There was effective teamwork and visible leadership across the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers. Complaints were resolved in a timely manner and shared with staff to aid learning.

However, we also found that:

- There were 243 elective operations cancelled on the day of surgery between July 2015 and June 2016. The most frequent reason for these cancellations was bed unavailability.
- Bed occupancy levels were high and 526 medical patients were admitted to the surgical wards between February 2016 and July 2016. The hospital had launched 'Home First' initiative, which aimed to reduce bed occupancy by supporting suitable patients to receive care in their own place of residence.

# Surgery

- Medicine fridge temperatures were not always maintained at the recommended temperatures. This was being addressed through staff training and the use of improved documentation to log temperatures.

## Are surgery services safe?

Good



We gave the surgical services at the Tameside General Hospital an overall rating of 'good'. This was because:

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- Medicine fridge temperatures were not always maintained at the recommended temperatures. This was being addressed through staff training and the use of improved documentation to log temperatures.

## Incidents

- The surgical services reported one 'never event' between June 2015 and May 2016. A 'never event' is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The 'never event' related to a retained item (surgical swab) in September 2015. The incident was investigated to determine the root cause. The investigation report highlighted a number of factors that contributed to the incident; including multiple doctors involved in the complex procedure which may have resulted in no-one taking accountability for the final swab count and staff disruption caused by nurses being moved or changed during procedures with poor handover.
- Remedial actions taken following the incident included additional training for surgical staff and updating the swab count procedure in June 2016 to outline responsibilities for swab counts and instructions for staff to follow if staff changes or handovers occurred during a procedure.
- The Strategic Executive Information System (STEIS) data showed there were three serious patient safety incidents reported by the surgical services between June 2015 and May 2016. This included two instances of pressure ulcers and the surgical procedure incident that was also reported as a 'never event' (retained surgical swab).
- We saw evidence to show these incidents were investigated and remedial actions were implemented to improve patient care. The trust also reported that one of the pressure ulcer incidents (August 2015) was reported on STEIS for awareness however related to a non-hospital acquired pressure ulcer.
- Staff were aware of the process for reporting any identified risks to patients, staff 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 to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matrons or clinical leads.

# Surgery

- Incidents and complaints were discussed during daily 'safety huddles' and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide alerts and monthly newsletters.
- The incident reporting system provided prompts for staff to apply duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The serious incident reports we looked at showed that duty of candour principles were applied including a formal apology and explanation to the patient or their representatives from the clinician involved in their care and treatment.
- Patient deaths were reviewed by individual consultants. These were also presented and reviewed during monthly mortality and morbidity meetings and divisional quality and safety 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 April 2015 and April 2016 showed there were two pressure ulcers, no falls with harm and four 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 infection or Clostridium difficile (C.diff) infections relating to surgery at the hospital during the past 12 months.
- Public Health England data for surgical site infections during 2015 showed the infection rate following fractured neck of femur (hip) surgery was 1.7% compared with a national average of 1.5% during this period. The infection rate following breast surgery was

2.7% compared with a national average of 4.2%. This showed the hospital performed similar to or better than the national average for the proportion of patients that acquired surgical site infections following surgery.

- The wards and theatres we inspected were clean and safe. 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 were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Visitors were encouraged to wash their hands.
- 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.
- A monthly hand hygiene and 'bare below the elbow' audit was carried out across the wards and theatre areas. Audit results from December 2015 and May 2016 showed high levels of compliance by staff (92% to 100%). Where hand hygiene issues were identified this was discussed with individual staff members to improve compliance.
- Infection control audits were carried out at least every three months to check the cleanliness of the general environment and equipment. Audit results for 2015 showed compliance levels of 95% and above were consistently achieved across the ward areas.
- Audit results for the theatres from January 2016 showed overall compliance was 81%, with issues identified in the domestic room and the general cleanliness of the environment (e.g. dust on workstations and clutter in some theatre areas). Where compliance was not fully achieved, remedial actions were put in place and these were followed up to minimise the risk of spread of infection.

## 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 the equipment we saw 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 and 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.
- A new medication fridge had been installed on the surgical unit; however, during the inspection the fridge thermometer showed a maximum temperature of 9.8°C. We discussed this with the ward manager who took immediate action to remove the affected medicines from use.
- During the unannounced inspection, we saw that further remedial actions had been taken. A new daily temperature log form was put in place across the surgical wards and ward staff had received additional training on how to correctly record fridge temperatures and what actions to take if fridge temperatures exceeded the recommended temperature ranges.
- We saw that fridge temperatures across the surgical wards were recorded as between 0°C and 8°C during 13 to 18 August 2016. As an additional measure, the daily temperature logs were also being counter-signed by a member of the pharmacy team for two weeks to monitor staff compliance in recording of fridge temperatures across the surgical wards.
- We spoke with five patients about their medication and looked at nine sets of medication records. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately.
- An audit of antibiotic prophylaxis in surgical procedures carried out in February 2016, based on a sample of 30 patient records. The audit results showed 95% of antibiotics given for surgical prophylaxis were appropriate in the choice, the timing of administration and the duration post-operatively.

## 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.
- We found that medicines were ordered, stored and discarded safely and appropriately.
- We saw that medicines that required storage at temperatures between 0°C and 8°C were stored in medicine fridges. Fridge temperatures were monitored daily; however, we found the fridge temperatures in some surgical wards were not always maintained at the recommended temperatures.
- For example, on the surgical unit fridge temperatures of 23.9°C had been recorded on ten consecutive days in July 2016 and temperatures below 0°C had been recorded for 11 consecutive days during June and July 2016. There was no evidence that any remedial action had been taken or recorded.

## Records

- Staff used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for 16 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 these 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.

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## Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 100% of staff across the surgical services had completed training in safeguarding adults (minimum level 2 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 displayed in the areas we inspected. Each area also had safeguarding link nurses in place. Staff were aware they could seek advice and support from the hospital-wide safeguarding team.
- Safeguarding incidents were reviewed by the departmental managers and also by the hospital's internal safeguarding board, which held meetings every two months to review individual incidents and to look for trends.

## Mandatory training

- Staff received mandatory training in key areas such as fire safety, health and safety, resuscitation, infection control, information governance, moving and handling, equality and diversity and safeguarding of vulnerable adults and children.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. The training was delivered either face-to-face or via e-learning.
- Records up to June 2016 showed that overall training compliance for staff across the surgical services was 87%. This showed the majority of staff had completed their mandatory training. However, the hospital's internal target of 95% compliance in mandatory training had not been achieved.

## 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 (blood clots), 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 national early warning score systems (NEWS) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- A NEWS audit was completed in May 2016 and the findings were based on a review 66 records across the surgical wards. The audit showed that staff compliance in completion of NEWS charts was inconsistent across the seven standards outlined in the audit.
- The audit showed staff across the surgical wards demonstrated good compliance in areas such as recording observations for respiratory rate, oxygen saturations, heart rate, blood pressure, consciousness levels and temperature (96% to 100%). However, poor compliance was identified in areas such as increased monitoring where a patient had abnormal physiology or evidence that patients were appropriately escalated for medical input or to the critical care outreach team when required.
- The NEWS audit report listed a number of actions to further improve compliance, including providing refresher training and training tools for staff to recognise and escalate NEWS concerns and a review of the observation charts to support clearer documentation.
- A NEWS improvement project was underway and a project manager was put in place to design, co-ordinate and monitor the improvement programme in May 2016. The remedial actions for the NEWS audit were scheduled for completion by January 2017. Progress against agreed actions was monitored through the trust-wide managing deteriorating patients group (MDPG).
- We observed six 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 routine audits to monitor adherence to the WHO checklist by reviewing a random selection of completed checklist records. The audit report for July 2016 showed 100% compliance with the use of the checklist and the filing in patient case notes.



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- The audit also showed that only 31% of checklists were fully completed in all sections. Information was omitted or incomplete in a number of areas, such as the 'patient discussed in team brief' box (completed in 69% of cases), printed name (57%), and signature of the staff completing the checklist (74%) and date recorded (88%).
- Remedial actions taken to improve compliance included raised awareness and additional training for staff and the launch of a revised checklist in June 2016 to aid staff in completing the checklist records.
- Further audits were scheduled to take place every three months to monitor staff compliance. The theatre staff were collaborating with a neighbouring acute trust to develop a process for carrying out observational audits in addition to the WHO checklist records audit currently in place.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. Staffing levels were maintained through the use of the 'NHS Professionals' agency and mostly based on existing staff working additional hours.
- The ward managers and the matron for theatres told us they used existing staff or regular 'agency' staff that were familiar with policies and procedures. They also told us permanent trained staff accompanied temporary staff where possible, so that patients received an appropriate level of care. External agency staff were rarely used but they underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment.
- The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that patients with greater dependency following their surgery were provided with 1:1 care across the surgical wards.
- 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.

## 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.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Records up to April 2016 showed the vacancy rate for nursing staff across the surgical wards was less than 1%. The planned orthopaedic unit (POU) and emergency orthopaedic unit (EOU) had minimal vacant posts. Each unit had a vacancy for a band five nurse and recruitment for these was on-going.
- The surgical unit (SAU) had five whole time equivalent (WTE) band five nursing vacancies and one WTE healthcare assistant vacancy. There were three newly qualified nurses and a nurse transferring from another ward scheduled to commence employment on the ward by September 2016 to address the shortfall.
- The theatres had 10 WTE anaesthetic staff vacancies and the theatres department were actively recruiting to fill these posts. The matron for theatres told us 15 staff had been appointed to participate in a bespoke anaesthetic course in collaboration with a local university. Once completed these staff would be competent in both anaesthetic and recovery specialties.

## 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 was greater than the England average. The proportion of consultants was below the England average (39% compared with the England average of 43%). The proportion of registrar group doctors was also below the England average (18% compared with the England average of 35%).
- The clinical lead for surgery told us the majority of consultant and middle grade posts were fully recruited to and close to the full establishment.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. For example, there were two locum posts in the orthopaedics specialty, with one filled by a long-term locum doctor and the other post currently advertised for recruitment. A locum doctor was also used in the ear, nose and throat (ENT) specialty to provide cover for maternity leave.

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- 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.
- Staff rotas showed there was sufficient on-site junior and middle grade medical cover across each specialty over a 24-hour period. Daily medical handovers took place during shift changes and these included discussions about specific patient needs.
- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.

## Major incident awareness and training

- There was a documented major incident plan in place and this listed key risks that could affect the provision of care and treatment. Surgical staff were aware of how to access this information when needed.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Records showed 97.6% of staff across the surgical services had completed resuscitation training and staff had guidelines in place for dealing with medical emergencies such as a patient going into cardiac arrest.

## Are surgery services effective?

Good



We rated the surgical services at Tameside General Hospital as 'Good' for being effective. This was because: -

- The services provided effective care and treatment that 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.

- Most surgical specialties performed in line with the England average for the proportion of patients readmitted to the hospital following discharge. Actions were being taken to improve the surgical specialties where readmission rates were higher than expected.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Most staff had completed their annual appraisals (95.6%) and the hospital's internal target for 90% appraisal completion was achieved.
- 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.

However, we also found that: -

- The services achieved full compliance in only two of the 10 standards in the national emergency laparotomy audit (2016). There were planned actions in place to improve compliance with the standards had not been achieved.

## 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 specialties, such as orthopaedic surgery. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.
- During 2015/16 the trust participated in 100% national clinical audits (26) and 100% clinical outcome review programmes (three) which it was eligible to participate in. The local audit programme for surgery listed 65 local audits that the services were currently involved in.
- Findings from clinical audits were reviewed at monthly quality and clinical governance meetings and any changes to guidance and the impact that it would have on their practice was discussed.



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- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a selection of the hospital's policies and procedures 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.
- The patient records we looked at 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 and their pain symptoms were managed appropriately.
- There was a dedicated pain team within the hospital 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.
- Patient records showed fluid balance charts were in place and these were complete and up to date. The 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 requiring assistance 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 2015 showed that the hospital performed better than the England average for six out of the 10 indicators, including the number of patients admitted to orthopaedic care within four hours, the number of patients developing pressure ulcers, bone health and falls assessments and the total the length of patient stay at the hospital.

- The audit showed 81.7% of patients received pre-operative assessment by a geriatrician compared with England average of 85.3%. The clinical director for surgery told us that ortho-geriatrician cover was put in place for weekends approximately 10 months ago and this is expected to lead to improved compliance with this measure in the next hip fracture audit.
- The 2015 hip fracture report also highlighted that the hospital performed worse than the England average for case ascertainment rate, the number of patients having surgery within 36 hours of admission and for mean length of acute stay.
- The national bowel cancer audit of 2015 showed that the hospital performed similar to the England average and was rated 'good' for case ascertainment rate and data completeness. The hospital also performed similar to the average for the percentage of patients that were seen by a nurse specialist (93% compared with the average of 93%).
- The national emergency laparotomy audit (NELA) 2016 showed that the hospital performed achieved 'green' (70-100%) compliance for two of the 10 standards; case ascertainment and the proportion of patients with computed tomography (CT) scan reported prior to surgery.
- The hospital achieved 'amber' (50-69%) compliance for six out of the 10 standards and achieved 'red' (0-49%) compliance for the remaining two standards; pre-operative review by consultant surgeon and anaesthetist and assessment by a medicine for care of the older person (MCOP) specialist.
- There was an action plan in place to improve against the NELA standards that had not been fully achieved, such as liaising with the medical services to support the standard for routine daily input from elderly medicine, to optimise dietitian input on the surgical wards and a review of the emergency on-call consultant cover to ensure timely review of patients.
- The national joint registry (NJR) data between April 2003 and July 2015 showed that hip and knee mortality rates at the hospital were in line with national averages.
- Performance reported outcomes measures (PROMs) data between April 2014 and March 2015 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement was similar to the England average.

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- The proportion of patients with improved outcomes following varicose vein procedures was worse than the England average during this period; however, the outcomes data may be affected by low numbers of this procedure conducted at the hospital.
- 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 and ear, nose and throat (ENT) surgery.
- The clinical director for surgery told us readmission rates were routinely reviewed and likely causes included surgical site infections or readmissions following specific procedures such as tonsillectomy (removal of tonsils).

## Competent staff

- Newly appointed staff had an induction for up to four weeks and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- The theatres department had a practice educator that oversaw training processes and carried out competency assessments based on national competency guidelines.
- Staff told us they routinely received supervision and annual appraisals. Records up to June 2016 showed the appraisal rate across the surgical services was 95.6%. This showed the majority of staff had completed their annual appraisals and the hospital's internal target of 90% appraisal completion was achieved across all the surgical services.
- Records showed all eligible medical staff in the surgical services that had reached their General Medical Council revalidation date had been reviewed within the recommended time scale or had a planned review date in place.
- The nursing and medical staff we spoke with 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. The patient records we looked at showed 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, occupational therapists 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.
- There was a 24-hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The pharmacy was also open for a limited number of hours on Saturdays and Sundays. Staff could also access an emergency drugs cupboard if needed during out-of-hours or on weekends.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

## Access to information

- We saw that information such as audit results, performance information and internal correspondence were displayed in all the areas we inspected. Theatre

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staff used visual in-brief boards to aid planning. Ward staff also used visual boards to identify patients with specific needs, such as patients living with dementia or at risk of falls.

- Staff used pre-printed care pathway booklets for individual procedures, such as for fractured neck of femur (hip) surgery, and these were version-controlled and readily available.
- Staff could access information such as policies and procedures from the hospital's intranet. Staff told us they could access up to date national best practice guidelines and prescribing formularies when needed.
- The hospital used paper based patient records. The patient 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.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to obtain 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.
- Consent records showed the risks and benefits of the specified surgical procedure were clearly documented and had been explained to the patient.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. We saw evidence of this in the patient records we looked at.
- Patient records showed that staff carried out mental capacity assessments for patients that lacked capacity to make an informed decision about their treatment. We looked at three patient records where a DoLS application had been made and the records for this had been completed correctly.

- There was a hospital-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.

## Are surgery services caring?

Good



We rated the surgical services at Tameside General Hospital as 'good' for being caring. This was because:

- We spoke with 12 patients and the relatives of two patients. They all spoke positively about the care and treatment they received. They told us they were treated with dignity and compassion and their privacy was respected.
- Patients and their relatives were kept fully involved in their care and the staff supported them with their emotional and spiritual needs.
- Patient feedback from the NHS Friends and Family Test between April 2015 and July 2016 showed the three surgical inpatient wards, the day case unit and the endoscopy unit had an average score above 97%. This showed that most patients were positive about recommending the surgical services to friends and family.
- **Compassionate care**
  - We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner in the wards and theatre areas.
  - Patients' bed curtains were drawn when providing care and treatment 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. The privacy and dignity of patients being transferred to the theatre areas was maintained and patients were provided with gowns and blankets.
  - We spoke with 12 patients and the relatives of two patients. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in

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which staff showed them respect and ensured that their dignity was maintained. The comments received included: “tremendous staff”, “really good care” and “can’t fault any of the staff, feel really looked after.”

- The NHS Friends and Family Test is a satisfaction survey that measures patients’ satisfaction with the healthcare they have received. The test data between April 2015 and July 2016 showed the three surgical inpatient wards, the day case unit and the endoscopy unit had an average score above 97%.
- The survey scores were similar to the England average during this period and indicated that most patients were positive about recommending these wards to friends and family.
- The average response rate (the percentage of patients that completed the survey out of all eligible patients) was better than the England average of 30% across three of the surgical inpatient wards. However, the average response rates for the day case unit (19%) and endoscopy unit (13%) were less than the England average.
- The endoscopy unit manager told us they encouraged patients to complete the survey prior to being discharged and the low response rates may due to discrepancies in the way the survey data was reported.
- **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. Staff were respectful and sought permission from patients before they delivered care or treatment.
  - Patients and their relatives 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.
  - Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. The comments received included: “really good care, informed about what is happening” and “very informative, consultants keep up to date with what is happening”.

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- 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.
- Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. One patient commented that the “nursing staff have more time for you” and that the medical and nursing staff were supportive.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services. Staff told us they could contact the hospital’s palliative (end of life care) team for support and advice during bereavement.

## Are surgery services responsive?

Good



We rated the surgical services at Tameside General Hospital as ‘Good’ for being responsive to patient’s needs. This was because: -

- The surgical services performed better than the England average for 18 week referral to treatment waiting times across most specialties. Actions were taken to improve compliance in the surgical specialties where these standards had not been achieved, such as for trauma and orthopaedics.
- The theatre service improvement project included actions to improve efficiency and minimise patient delays, through measures such as the ‘golden patient’. The project had led to improvements such as 72% of theatre lists starting on time in June 2016 compared with 10.4% in September 2015.
- There had been no non-elective (emergency) surgery operations cancelled between July 2015 and June 2016. The services also performed better than the England average for the number of patients whose operations were cancelled and were treated within the 28 days.

## Emotional support

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- The 'Home First' initiative was being piloted in the planned orthopaedic unit. This aimed to reduce bed occupancy by supporting suitable patients to receive care in their own place of residence.
- There were systems in place to support vulnerable patients. Staff applied 'reasonable adjustment' principles for patients with learning disabilities and care plans were in place to instruct staff on how to care for patients with learning disabilities.
- The majority of complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

However, we also found that: -

- There were 243 elective operations cancelled on the day of surgery between July 2015 and June 2016. The most frequent reason for these cancellations was bed unavailability. Bed occupancy levels were high and 526 medical patients were admitted to the surgical wards between February 2016 and July 2016.

## **Service planning and delivery to meet the needs of local people**

- Hospital episode statistics data showed 16,436 surgical procedures took place at the hospital between March 2015 and February 2016. The data showed that approximately 65% of patients had day case procedures, 15% had elective surgery and 26% were emergency surgical patients.
- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, oral and maxilla-facial surgery, ear, nose and throat (ENT) surgery, breast surgery, ophthalmology, plastic surgery and general surgery (such as colorectal).
- There were arrangements in place with neighbouring hospitals to allow the transfer of patients for surgical specialties not provided by the hospital, such as neurosurgery and vascular surgery.
- The ward and theatre areas we inspected were compliant with same-sex accommodation guidelines.
- There were daily meetings with the bed management team so patient flow could be maintained and to identify and resolve any issues relating to the admission or discharge of patients.
- A centralised booking team had been put in place during 2015. The team consisted of a team leader and

12 access team staff. All patients requiring surgery at the hospital were booked through the central booking team. There were weekly meetings between the booking team and theatre staff to plan and schedule theatre lists.

## **Access and flow**

- 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 that patients were assessed upon admission to the wards or prior to undergoing surgery.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- 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 hospital-wide bed occupancy rate between September 2014 and March 2016 ranged was approximately 90%. This was reflected in the surgical wards we visited as we found that most available beds were occupied.
- Records showed that between February 2016 and July 2016 there were a total of 526 medical patients admitted across the three surgical wards (medical outliers). Staff on the surgical wards told us medical outlier patients were seen daily by medical doctors.
- The ward managers told us it was very rare for a surgical patient to be placed on a medical ward. However, there were instances where surgical patients were placed in another surgical specialty ward. For example, we saw a number of general surgery patients were placed on the orthopaedic wards due to lack of bed availability on the surgical unit.
- The surgical consultants and doctors had a list of patients that were placed in other wards so these patients could be reviewed daily. Patient records showed that patients were reviewed by doctors from the relevant surgical specialty on a daily basis.



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- The hospital planned to reduce bed occupancy through the launch of the 'Home First' initiative, which aimed to reduce patient length of stay by supporting a 'Discharge to Assess Model'.
- The 'Home First' initiative was being piloted in the planned orthopaedic unit. The initiative was based on an integrated urgent care team consisting of health, social care and voluntary sector professionals that facilitated patients to have their care requirements met within their own place of residence, where possible.
- The average length of stay for elective patients was better than the England average for all specialties except colorectal surgery. The clinical director for surgery told us staff compliance in the use of enhanced recovery pathways for colorectal surgery was being reviewed to reduce patient length of stay.
- The average length of stay for non-elective patients across all specialties was better than the England average for all specialties except general surgery. The clinical director for surgery told us this was mainly due to patients that experienced delayed transfers of care, such as elderly patients that required adult social care placements or care packages.
- Records for all operations cancelled across the surgical services showed there had been no non-elective (emergency) surgery operations cancelled between July 2015 and June 2016.
- NHS England data showed the number of last minute cancelled elective (planned) operations for non-clinical reasons was better than the England average from July 2015 to June 2016. The number of patients whose operations were cancelled and were treated within the 28 days was better than the England average for most of the period between January 2015 and March 2016.
- There were 467 elective operations cancelled between July 2015 and June 2016. This included 224 cancellations prior to day of surgery and 243 operations that were cancelled on the day of surgery.
- The most frequent reasons for cancelled elective operations prior to day of surgery were 'provider cancellation' (33%) and 'bed unavailability' (25%). The most frequent reasons for cancellations on the day of surgery were 'bed unavailability' (36%) and 'theatre overrun' (16%).
- The theatre service improvement project started in November 2015 and reducing same day cancellations was one of the key focus areas for the project. Actions taken to reduce cancellations included the creation of a 'cancellation form' to accurately record the reasons for cancellation and a database detailing all cancellations with responsibilities for determining the cause for each cancellation and documenting whether this was avoidable / unavoidable and actions taken.
- The central booking team developed patient leaflet in May 2016 aimed at reducing cancellations on the day. This advised patients to inform the hospital in advance if there were any conditions that could impact on their procedure (e.g. infection, rash, feeling unwell or taking medication such as antibiotics) in order to avoid cancellation on the day of surgery.
- In April 2016 an escalation process was rolled out to allow senior staff oversight of any potential cancellation for a non-clinical reason (e.g. bed availability). Reducing cancelled operations was also identified as a key performance indicator for the theatre service improvement project and progress was reported on monthly to the executive director of operations via the trust service improvement group.
- NHS England data showed the hospital performed better than the England average for 18 week referral to treatment (RTT) waiting times for admitted patients between August 2015 and March 2016 for all surgical specialties except trauma and orthopaedics (71.3% compared with the average of 72.3%).
- Hospital records between February 2016 and July 2016 showed the incomplete pathway standard was achieved across most surgical specialties. However, the trauma and orthopaedics specialty averaged 86.4% during this period. The incomplete standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment.
- A number of actions had been taken to improve compliance with RTT standards for trauma and orthopaedics. This included an increase in consultant numbers and new theatre timetables to enable consultants to have the capacity for their procedures.
- Records between August 2015 and July 2016 showed the average monthly theatre utilisation (efficiency) ranged between 78% and 89%, compared to the hospital target of 90% utilisation.
- The theatre service improvement project included actions to improve utilisation and minimise patient delays (e.g. late starts). This included the 'golden patient', which allowed low risk adult day case patients

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with a completed anaesthetic preoperative assessment and clear surgical plan to be selected for surgery at the start of a theatre list in order to reduce delayed start times.

- Records showed there had been sustained improvement over time and 72% of theatre lists started on time in June 2016 compared with only 10.4% lists starting on time in September 2015. The hospital's internal target was 90% and theatre service improvement project aimed to continue to drive improvements.

## 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 'passport' document for patients admitted to the hospital with dementia or a learning disability. 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.
- Staff could contact the hospital-wide safeguarding team for advice and support for dealing with patients living with dementia. There was a hospital-wide lead nurse that provided staff with guidance and support when caring for patients with learning disabilities.
- Staff could also contact the rapid assessment, interface and discharge (RAID) team for support and advice when treating patient with mental health conditions. The RAID service was based at the hospital but provided by a neighboring mental health trust.
- Patient records included 'enhanced' care plans for patients living with dementia to allow staff to provide appropriate care by considering 1:1 care and the use of distraction techniques.
- Ward staff told us they applied 'reasonable adjustment' principles for patients with learning disabilities and we saw specific care plans were in place to provide guidance for staff on how to care for patients with learning disabilities.
- We looked at three patient records where 'reasonable adjustment' care plans were in place. The care plans

took into account factors such as the environment, communication (e.g. use of communication books or easy read leaflets), staffing, equipment requirements and procedures (such as booking patient first or last on list).

- 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 main theatres had a designated paediatric recovery bay 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 staff.
- The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.
- Staff told us that information about complaints was discussed during daily 'safety huddles' and at routine team meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.
- There were 35 complaints raised across the surgical services between August 2015 and July 2016. The most frequent reasons for complaints were 'clinical treatment' and 'patient care'.
- The hospital's complaints and concerns policy stated that complaints would be acknowledged within three working days and responded to within 25 working days for routine formal complaints or within 45 days for complex complaints that required detailed investigation.
- The majority of complaints about the surgical services were responded to in a timely manner. Records showed 32 complaints had been responded to and three complaints were still being investigated. Of the complaints that had been responded to, 31 (97%) were responded to within agreed timelines, and the remaining complaint was responded to three days later than the agreed timelines, due to the complexity of the complaint.

# Surgery

- The surgical wards and theatre areas also recorded compliments received from patients and their relatives and records showed 1,340 compliments were received between August 2015 and July 2016.

## Are surgery services well-led?

Good



We rated the surgical services at Tameside General Hospital as 'Good' for being well-led. This was because: -

- The hospital's values and corporate objectives had been cascaded across the surgical services and staff had a clear understanding of what these involved.
- Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional governance and quality and safety meetings.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.
- There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the services and how to resolve these.

### Vision and strategy for this service

- The trust mission statement was; "At Tameside General 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 2014/15 listed six key objectives: to provide harm free care through the implementation of the trust's patient and service user safety programme, improving quality of care through the implementation of the trust's quality strategy, to improve patient and service user experience, to facilitate the development of community integration

plans, to develop an integrated care model as part of the five year transformation and sustainability plan and to deliver as part 'Greater Manchester health and social care devolution' framework.

- The division of surgery / women and children 'service development strategy' 2016-18 listed a number of key targets linked to the corporate objectives, including improving responsiveness to patients in need of planned care through delivery of 18 weeks RTT standard, to work collaboratively towards 'Greater Manchester Healthier Together Emergency Standards' and to improve outcomes for trauma and orthopaedic patients through 'Get it Right First Time' collaborative working.
- The mission statement, values and objectives had been cascaded to staff across the surgical services and staff had a good understanding of these.

### Governance, risk management and quality measurement

- There were monthly divisional and specialty level governance and quality and safety and monthly departmental staff meetings across the surgical services. There was a set agenda for these meetings with standing items, including the review of incidents, key risks, audit findings 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 divisional risk register 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.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives (e.g. patient safety, staffing and training).
- Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to ward and theatre managers through performance dashboards.

### Leadership of service



# Surgery

- The overall lead for the service was the divisional director of operations, who was supported by the clinical director for elective surgery and the assistant chief nurse.
- The surgical wards were led by ward managers that reported to the matron for surgery and outpatients. The matron for theatres, endoscopy and anaesthetics was appointed in September 2016 and was supported by three team leaders (including a practice educator) in the main theatres and unit managers in the endoscopy and day case units.
- There were also two directorate managers in place; one for surgery / specialist surgery and one for theatres and anaesthetics. They managed a team support managers covering the surgical specialties.
- 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 we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

## Culture within the service

- The staff we spoke with 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.
- Records between August 2015 and January 2016 showed the average monthly staff sickness rate across the surgical services was 4.5% and this was comparable to national averages during this period.
- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of the 'NHS Professionals' agency that mostly consisted of existing staff working additional hours.

## Public engagement

- Staff across the surgical services told us they routinely engaged with patients and their relatives to gain feedback from them. This was done formally through participation in the NHS Friends and Family test and by conducting monthly and six-monthly patient feedback surveys.

- Patient feedback surveys asked for feedback in 24 areas, including overall satisfaction, communication, staffing and cleanliness. We looked at a selection of monthly survey responses for the wards, endoscopy and theatre areas for the period between December 2015 and May 2016.
- Each surgical area had received between 24 and 77 responses per month during this period and the feedback was positive (89% to 93%). This showed the majority of patients were satisfied with the care they received.

## Staff engagement

- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards, theatres, and day case and endoscopy areas. 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 medical and nursing staff participated in routine training days and staff forums (e.g. patient and staff, quality and safety forum – PASQAF). These included engagement, training and discussions around improvements to clinical processes.
- The trust carried out a patient safety event in May 2016 and this included information for staff on patient safety projects and improvements carried out across the trust and training sessions for staff across the trust.
- The trust carried out annual staff awards and the surgical staff participated in these. For example, the booking team leader won 'leading and inspiring others award' in August 2016 and the endoscopy service had also been nominated for a staff award.
- Staff across the surgical services participated in staff 'friends and family' feedback surveys every three months. Feedback was sought on 29 questions ranging from teamwork, communication, leadership and welfare. We looked at the feedback results for April 2014 and June 2016 and the feedback was mostly positive (range from 73% to 97%).

## Innovation, improvement and sustainability

- The theatre service improvement project was started in November 2015 and had resulted in improvements in

# Surgery

theatre efficiency. The services had implemented initiatives such as the 'golden patient', which had helped to significantly reduce the number of theatre list late starts.

- The hospital planned to reduce bed occupancy through the launch of the 'Home First' initiative, which aimed to reduce patient length of stay by supporting patients, where possible, to have their care requirements met within their own place of residence.
- All the staff we spoke with were confident about the sustainability of the surgical services at the hospital. They felt the facilities and workforce enabled patients to receive a good standard of care and treatment.
- The divisional director of operations, the clinical director and the matrons told us the key risks to the service were around maintaining nursing staff levels and their ability to improve theatre efficiency and patient access and flow processes. However, they were aware of how to address these issues and detailed action plans were in place to improve the services.

# Critical care

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

## Information about the service

The critical care service at Tameside General Hospital is delivered in a nine bedded unit. Situated on the 1st floor of the hospital, the unit is for adult patients only and admits around 400 patients a year, flexing the beds as required to accommodate both level 2 and level 3 patients. The unit can safely manage up to seven level 3 patients. The admissions are primarily non-surgical in origin. The unit is an active member of the Greater Manchester Critical Care Network (GMCCN).

Building and refurbishment work was planned to start in the unit within the coming weeks, which include an assisted bathroom and an increase in the number of isolation facilities. For the anticipated 12 weeks duration of the building works, the critical care service is planning to re-locate temporarily into the area on the ground floor that was formerly used as a high dependency unit.

For the purpose of management and governance, the critical care service sits in the critical care, theatres, endoscopy and anaesthetics directorate which in turn sits in the surgery/women and children division. As part of the inspection we spoke with relatives, patients and staff of all grades including nurses, doctors, consultants and allied health professionals. We also looked at policies, procedures, medical records, performance and quality data.

## Summary of findings

We have rated critical care services as “Good” overall. This is because;

- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients.
- We found a culture where incident reporting and learning was embedded and used by staff.
- Care was delivered in line with evidence- based, best practice guidance
- There was strong clinical and managerial leadership at unit and divisional level.
- There was an effective governance structure in place.
- Patients and their relatives were cared for in a supportive and sympathetic manner and were treated with dignity and respect.

However,

- The data showed there was an issue with comparatively high numbers of out of hours discharges when compared with similar units.
- There was an issue with some referrals from the physician led teams not always following the admission/escalation policy.

# Critical care

## Are critical care services safe?

Good



We rated critical care services as “Good” for Safe because;

- There were systems in place for reporting and learning from incidents. This included evidence to support that learning had taken place as a consequence of incidents being reported and investigated.
- 100% harm free care for the past four months.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse and neglect.
- There was a comprehensive system for monitoring the maintenance of all devices and equipment.
- A range of acute care initiatives had been introduced to assist with the early detection, recognition and timely response to the acutely ill patient and those at risk of deterioration.
- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients.

However,

- Whilst we saw a strict ‘bare below the elbows’ regime, hand hygiene audits had reported some non-compliance.
- The critical care environment did not fully meet the latest health building guidance. Though a planned refurbishment would upgrade the existing facilities.
- Not all discharge summaries were properly completed.

### Incidents

- The hospital had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff knew about the incident reporting system and were able to give examples of when they had used it. This included describing what constituted a reportable incident.
- The trust had recently been rated as outstanding for openness and transparency. Being positioned at number 8 in a national ‘learning from mistakes league’ published in March 2016 by Monitor and the trust development authority (TDA).
- For the period June 2015 to May 2016, the data provided by the trust showed that there were 204 incidents

reported from critical care. These included a range of incidents such as accidental injury, failure to follow procedures, medication errors, pressure ulcers and staffing issues.

- Of the 204 reported incidents, the majority (173) were categorised as causing no harm. Then 26 were reported as causing low harm with the remaining five incidents causing moderate harm. The incidents causing moderate harm related to pressure ulcers (3), medication and accidental injury. None of the reported incidents had been categorised as being serious.
- The trust produced a newsletter called ‘Closing the Loop’. The newsletter aimed to capture areas of patient and staff safety, satisfaction and to share learning from incidents, complaints and audit across the organisation. For example, the June 2016 edition of Closing the Loop included a section on learning from inoculation injury incidents. The trust had approximately six inoculation incidents per month and the feedback included information for staff on the changes being made to make practice safer.
- We saw that the trust was offering monthly drop in sessions for all staff in the education centre on reporting and managing incidents.
- A Mortality Steering Group was established in January 2014 as part of the Trust organisational improvement programme, and overarching quality improvement strategy. The group was tasked with implementing a mortality strategy which incorporated a standardised review of all hospital deaths. From February 2014 all hospital deaths have been reviewed to ensure that the care is understood and all opportunities to learn are utilised. The critical care team were pro-active in the mortality review process and reviewed all deaths that occurred in the critical care area, feeding outcomes into the mortality steering group. The lessons learned were disseminated through the divisional governance structure to ensure appropriate actions were embedded and learned from. Critical Care presented and discussed mortality cases at the Critical Care Mortality meeting. A Mortality News Update (MNEWS) was distributed bi-monthly to the clinical teams reflecting outcomes of mortality reviews – good practice and areas for improvement to the clinical teams for discussion in forums and at ward level meetings.
- We asked staff about their understanding of the principles of ‘duty of candour’. Staff responded by saying that it was their responsibility to be ‘open and honest’.

# Critical care

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

## Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer data was submitted from the unit and reported at divisional level. This included data on patient falls, pressure ulcers, urinary catheter related infections and episodes of venous thromboembolism (VTE).
- Up to date, safety thermometer data was displayed in the unit corridor outside the clinical areas. This showed 100% harm free care for the past four months in succession. Alongside was also displayed the staffing information for the day and night shifts, in terms of actual versus planned numbers of trained nurses and health care assistants on duty.

## Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- As part of the inspection we observed staff washing their hands appropriately, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care. We saw staff adhering to the 'bare below the elbows' policy when in the clinical areas.
- We saw that monthly hand hygiene audits were carried out by both the infection prevention and control team and the critical care staff. The critical care review of hand hygiene was part of a wider monthly infection and control audit that also looked at the environment and the use of personal protective equipment. The April 2016 hand hygiene audit showed full compliance, however, the May 2016 hand hygiene audit by the infection prevention and control team show eight instances of non-compliance with hand hygiene protocols from a sample of 23 staff. It is not clear from the data what actions arose as a consequence. The infection prevention and control team also undertook

quarterly environmental audits. The last report that we saw was for February 2016 and it reported an overall compliance rate for critical care of 88%. Again the report did not detail any actions arising from the audit.

- The most recently validated intensive care national audit and research centre (ICNARC) from April to September 2015 showed that for ventilated admissions, elective surgical admissions and emergency surgical admissions there had been no cases of unit acquired infections in blood.

## Environment and equipment

- The existing critical care area did not fully comply with the latest available health building guidance for critical care units (HBN 04-02). However, the unit was due to be refurbished and upgraded and we saw that the planning had taken into account HBN 04-02. Whilst the refurbished unit would not fully meet the guidance it would come closer than prior to the refurbishment. The upgrade was to include redecoration, improved lighting, the creation of an assisted bathroom and shower and an additional isolation facility. The building works were due to take place in the coming weeks, during which time the critical care provision would be transferred temporarily to the ground floor former high dependency area.
- Currently the unit had one isolation room available. This did not have a gowning lobby or variable pressure air flow.
- During the course of the inspection the critical care unit had eight out of nine bed spaces fully functional. The final bed area was out of use following a leak to the ceiling. This had now been repaired and the ninth bed was soon due to re-open.
- All bed spaces were fully equipped with the equipment required to care for a critically ill patient.
- The unit had a full time band four medical technician who supported nursing and medical staff by calibrating and setting up ventilators, haemo-filtration equipment, infusion pumps and syringe drivers. In addition the medical technician kept a comprehensive service log of the entire unit's equipment and ensured that servicing and maintenance was carried out in a timely way. We checked several items of equipment against the service log and found everything to be in order. The medical technician was being supported to undertake a Diploma in Electronic and Electrical Engineering, which would enable their role to be further extended.

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- We saw that resuscitation equipment; including defibrillators and difficult airway management trolleys were available. There was also an appropriately equipped transfer trolley kept on the unit corridor. Records indicated that these were all checked daily.

## Medicines

- Trust policies were regularly reviewed and covered most aspects of medicines management. These were accessible via the hospital intranet to all staff.
- Patients and staff had access to a critical care pharmacist with a senior pharmacist attending the unit Monday to Friday. The critical care pharmacist did not always attend the morning ward round but did visit every patient every day. Clinical pharmacist attendance at multi-disciplinary ward rounds increases the effectiveness of the service as recommended in the Intensive Care Society core standards.
- All drugs and intra-venous fluids were kept safely and securely in a locked clinic room. Access was only possible via an authorised swipe card. We were told by the pharmacist that there had been a local agreement that if the clinic room door remained locked and secure then the drug cupboards therein could be left unlocked. We saw that the controlled drugs were checked every shift by the unit staff and again periodically by the pharmacist.
- There were 35 medicines related incidents reported from critical care between June 2015 and the end of May 2016. The extract from the incident log that was shared with us gave no further details of the incidents themselves. One of the incidents was reported as causing moderate harm to a patient.
- Records indicated that drug fridge temperatures were monitored and recorded daily.
- We saw that trust wide there was a monthly antibiotic audit to establish the quality and appropriateness of antibiotic prescribing. The reports did not identify specific areas such as critical care in their results. The most common reason for non-compliance was that antibiotics were not prescribed in accordance with hospital guidelines.

## Records

- We looked at five sets of patient notes on critical care. Critical care notes were kept separately from the rest of the general hospital notes. The critical care paper records comprised a range of clinical records,

assessments and plans. These included for example, nutritional risks, falls assessments, delirium assessments, pain scores, capacity assessments, physiotherapy treatment plans and care bundles. All entries were completed, signed and dated although the legibility of handwritten notes varied.

- Although entries in records were usually signed and dated, the authors name was not always printed alongside the signature. Some entries were also missing the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- Physiological parameters were recorded by the nurse looking after the patient on a large chart located close to the bedside. This brought together all the patient monitoring and observations onto one chart so that ventilator settings, fluid balance and vital signs could all be reviewed in one place.
- We also looked three patient's discharge summaries. Two when they were still in critical care awaiting discharge and one for a patient who had been discharged back to the ward. As far as the ward patient was concerned their discharge summary was incomplete and poorly documented. This issue was raised with the outreach team at the time. The two discharge summaries seen on the unit were both completed appropriately.

## Safeguarding

- There were trust-wide safeguarding policies and procedures in place which were readily available on the trust's intranet site.
- There was an internal system for raising safeguarding concerns. Staff were aware of the process and gave examples of what constituted abuse and neglect.
- The unit had designated safeguarding 'managers' and their contact details were displayed on the corridor noticeboards. The trust also had an internal safeguarding team who provided guidance and support to staff in all areas. This team were accessible by telephone when required.
- Safeguarding training was part of the trust annual mandatory training programme. We saw trust wide figures for safeguarding training which reported the following levels of compliance; level one – 96%, level two – 74% and level three – 82%.



# Critical care

- The June 2016 trust publication called 'Closing the Loop' had a section produced in conjunction with Tameside Safeguarding Children Board, which set out an example seven minute briefing document for a children safeguarding concern.

## Mandatory training

- A mandatory training record was held for every staff member.
- Staff told us that they were encouraged to attend mandatory training and that the practice educators reminded them when their mandatory training was due for renewal. Mandatory training was a mixture of e-learning and face to face sessions.
- According to the latest figures for July 2016 the mandatory training completion figures for critical care were as follows; information governance (88.5%), equality and diversity (98.1%), health and safety (88.5%), fire safety (86.5%), infection prevention (82.7%), adult safeguarding (100%), children's safeguarding (80.8%), resuscitation (100%) and manual handling (100%).

## Assessing and responding to patient risk

- A range of acute care initiatives had been introduced to assist with the early detection, recognition and timely response to the acutely ill patient and those at risk of deterioration. These included, implementation of the national early warning score (NEWS) and associated acute care guidance and policies. NEWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically. The charts in use on the ward areas included an early detection and treatment of sepsis pathway as well as the NEWS scoring system and escalation plan.
- The trust complied with National Institute for Health and Care Excellence (NICE) guidance 50, 'Acutely Ill Adults in Hospital, recognising and responding to deterioration'. There was an outreach service but this was currently only provided from 7.15am to 8.15pm Monday to Sunday. Out of hours, when the outreach team was not available, arrangements were in place for the respective medical teams supported by night nurse practitioners to respond to a patient as required. During the week of the inspection, two new members of the outreach team had started working through their induction period. Funding had been granted to expand the outreach service for a trial period.

- The trust also provided a patient safety booklet, which explained how and why patients were observed and monitored and included an explanation of early warning scores.

## Nursing staffing

- The critical care matron kept a close overview of the staffing establishment. They understood exactly what the staffing situation was at the time versus the establishment for each band of staff working within critical care. The unit was budgeted for nine registered nurses per shift plus a supernumerary shift leader who was usually a band 7. The planned versus actual staff was recorded monthly and the latest figures we saw for April 2016 showed a shortfall in establishment for registered nurses of 4.31 WTE. The unit was up to establishment for health care assistants.
- The staffing establishment was calculated using the intensive care society 'Levels of Critical care for Adult Patients' guidance and the 'Safer Nursing Care Tool', which was based on the Department of Health's classification of critical care patients, published in 2000.
- The unit used an electronic rostering tool with a printed rota sheet for each shift that could be manually updated to reflect sickness, shift changes, agency and bank staffing.
- At the time of the inspection, there were adequate and appropriate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment. On the first morning of the inspection there were two band 7 nurses, two band 6 nurses, five band 5 nurses and a supernumerary band 7 on duty. They were supported on the shift by a newly qualified nurse in her supernumerary period, a health care assistant, housekeeping staff, a medical equipment technician and a student nurse. There were six patients at that time, three level 3 and three level 2.
- Many of the unit's nursing team were also on the hospital bank. So any vacant shifts on the rota were usually filled by bank staff familiar with the critical care unit. Agency nurses were used as a last resort and when they were used they went through a local induction, which included an assessment of their competencies. For example, before being able to administer intra-venous medications.

# Critical care

- In terms of allied health professionals, the most recent critical care network report showed that appropriate numbers and grades of respiratory physiotherapy, pharmacy, medical engineering and housekeeping were in place.
- We observed a structured nursing handover in the morning, which took place at 7am. The night shift leader briefly discussed each patient and their care to the whole of the incoming day shift. The briefing being based on a printed handover sheet. Following this the day shift supernumerary co-ordinator assigned individual nurses to each patient, ensuring continuity where possible. The nurses then undertook a bedside handover from the out-going nurse whilst the two shift leaders went through a more detailed handover which included messages around staffing, sickness and any planned admissions for the coming shift.

## Medical staffing

- Critical care had a designated consultant clinical director.
- There were nine consultants covering the critical care rota. None were intensivists but all had a particular interest in critical care and were members of the faculty of intensive care medicine (FICM).
- There was a consultant assigned to the unit Monday to Friday from 8am to 9pm. During this time the consultant had no other clinical responsibilities within the hospital. Out of hours and through the weekend another consultant was on call. The consultant to patient ratio was 1:9 or less depending upon occupancy.
- There were two consultant led ward rounds per day.
- The consultants were supported by middle grade doctors many of whom were permanent staff grades. There was also a middle grade doctor assigned to the outreach team.
- The middle grade doctor's rota was also supported by an advanced critical care nurse practitioner.
- There were no trainee doctors currently assigned to critical care.
- We attended a medical led multi-disciplinary handover at 8am, which was well structured and followed a set format with a standardised handover sheet. The handover was undisturbed with no distractions.

## Major incident awareness and training

- Critical care services had detailed plans for responding to the increased demands that a major incident would

make on the service, while continuing to provide care for existing patients. The plans took account of national legislation and guidance such as the Civil Contingencies Act (2004) and the NHS Emergency Planning Guidance (2005).

- There was a major incident policy in place which was accessible on the trust intranet.
- On the first morning of the inspection a major incident situation had been initiated following a nearby gas explosion. The critical care unit had been asked to ready itself for a potential admission from the accident and emergency department.

## Are critical care services effective?

Good



We rated critical care services as “Good” for Effective because;

- Care was delivered in line with evidence- based, best practice guidance. In order to benchmark its performance against comparable units the critical care service collected and submitted data to the Intensive Care National Audit and Research Centre (ICNARC).
- Consultant led ward rounds took place twice daily.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management.
- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Staff were appropriately trained, competent and familiar with the use of critical care equipment.
- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.

However,

- Whilst there was evidence of multi-disciplinary working, the ward rounds did not always include all relevant members of the multi-disciplinary team.

## Evidence-based care and treatment

- The critical care service used a combination of national and best practice guidance to determine the care they delivered. This included guidance from the Intensive Care Society and the National Institute for Health and



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Care Excellence (NICE). For example, NICE clinical guidance 50, 'Acutely Ill Patients in Hospital – recognition of and response to acute illness in adults in hospital'.

- The critical care unit was also subject to an annual peer review by the Greater Manchester Critical Care Network (GMCCN). The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification. The most recent review from May 2016 showed good levels of compliance across the service specification with only a few areas requiring further action. These included developing a robust plan to manage the disruption to patient care that will be caused by the temporary closure of the unit for building work.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust-wide intranet.
- There was a local audit plan for 2016/2017, which included the following topics; compliance with NICE clinical guidance 83, delirium scoring, ventilator associated pneumonia (VAP) and admission and discharge. In terms of audits completed, we saw the results of on-going audits of VAP, skin bundles, urinary catheter insertion, peripheral cannula insertion, enteral feeding and the management of central venous lines. Where an audit identified a shortfall in compliance or performance an action plan or improvement project was developed and implemented.

## Pain relief

- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a paper based pain scoring tool.
- There was access to the acute pain management team for support and guidance especially for those patients with complex pain.
- The trust had a pain management governance group, which met monthly. The critical care service was represented at this meeting.

## Nutrition and hydration

- We saw the critical care dietician attending the unit. They were not always part of the formal consultant led ward rounds but attend the unit to review all patients daily.
- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. This was especially important if a patient was admitted over the weekend when there was no dietetic input. Both enteral and parenteral stock feeds were available to start as per the feeding protocols
- Nutritional risk scores were updated and recorded appropriately in the patient notes we reviewed.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.

## Patient outcomes

- The critical care unit demonstrated continuous data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally. The most recently validated ICNARC data showed that the risk adjusted mortality ratio was 1.12 and within the expected range for comparable units.
- The latest ICNARC data showed that the unplanned readmission rate within 48 hours was within expected limits if slightly higher at 1.8% than for similar units (1.3%).
- For unit acquired infections in blood the unit was performing better than similar units and had no episodes of unit acquired infections in blood for the past two years.
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and this has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress.

## Competent staff

- Staff were appropriately trained, competent and familiar with the use of critical care equipment.
- All the staff that we spoke with stated that they felt supported not just clinically but also in developing their skills and competencies. All staff had an appraisal

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annually. The matron appraised the band 7 staff and then they in turn appraised the band 6 staff. The band 6 staff were then responsible for appraising the band 5 staff.

- The unit had a practice based educator funded by the GMCCN.
- All new staff worked through a supernumerary period. This was normally eight weeks in duration but could be extended if required, or shortened depending upon the existing competencies of the new starter. For example, they may have had previous critical care experience. Staff new to critical care were also supported to work through Step 1 national competency framework and the Greater Manchester Critical Care Skills Institute essential skills course. The percentage of nurses who had completed a post registration qualification in critical care was >60%.
- There were education boards for staff throughout the non-clinical areas of the unit. There was a 'topic of the month' poster presentation in the seminar room where staff took it in turns to work up the display for an agreed topic of interest. There was helpful information relating to the nurses' revalidation process.
- All nurses working in critical care had completed basic and intermediate life support training as a minimum.
- When agency nurses were used, the unit tried to obtain nurses who had regularly worked on the unit to provide some consistency. Agency staff had their competencies assessed before they worked unsupervised.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC).

## Multidisciplinary working

- Consultant led multi-disciplinary ward rounds took place each day. The time seemed to vary depending on what else was going on in the unit. Although members of the multi-disciplinary teams attended at some point during the day, they did not always attend at the same time. We did see evidence of the wider multi-disciplinary team attending for specific patients, like the community psychiatric nurse.
- There were also microbiology ward rounds undertaken every day.
- There was evidence of multi-disciplinary working around the discharge of patients involving medical, nursing and allied health professional staff.

- There was evidence that nursing and medical staff worked together as a team for the benefits of their patients. We saw minutes of multi-disciplinary meetings held regularly.
- There was an outreach team available seven days a week from 07.15am to 08.15pm and they worked closely with the critical care team both in following up recently stepped down or discharged patients and in discussing deteriorating patients on the wards.
- The follow up clinics for ex critical care patients were a good example of multi-disciplinary working with physiotherapy, outreach, dietetic, medical and psychology staff all coming together to help their patients.

## Seven-day services

- A consultant was available seven days a week, including outside normal working hours.
- The physiotherapy team provided a seven day service to the critical care unit during the day with an on call service out of hours.
- Dietetic, pain management, speech and language therapy, and pharmacy services were available Monday to Friday, 9am to 5pm and via on-call at weekends.
- Imaging and diagnostic services were provided during the working week and then on-call out of hours and at the weekend.

## Access to information

- There were two critical care records kept by the bedside, one for nursing documentation and one for the doctor's notes. The allied health professionals used the doctor's notes for their respective record.
- All the patient's physiological parameters, assessments, fluid balance and ventilator settings were recorded on a large critical care observation chart situated by the bedside.
- In accordance with NICE guidance CG50 (Acute illness in adults in hospital: recognising and responding to deterioration), the critical care team and the receiving ward team ensured that there was a formal documented and structured handover of care. This promoted a clear and accurate exchange of information between relevant health and social care professionals.

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

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- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.
- There was a patient on the unit during the inspection who was subject to a formal capacity assessment and this was being managed in accordance with trust policy and guidance.
- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient. Care plans stated that the CAM-ICU should be completed twice every shift. Examination of the patient records showed that this was carried out twice daily. The rationale being that delirium prolongs critical care and has long term sequelae. Early detection means earlier treatment. The CAM-ICU is an adaptation of the Confusion Assessment Method by Inouye (1990), the most widely used tool for diagnosing delirium by non-psychiatric clinicians. The CAM-ICU utilises yes/no questions for use with non-speaking mechanically ventilated patients.

## Are critical care services caring?

Good



We rated critical care services as 'Good' for Caring because;

- Critical care services were delivered by caring, compassionate and committed staff.
- We saw patients, their relatives and friends being treated with dignity and respect.
- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a well-established programme of follow up clinics for ex critical care patients, which was helpful in managing both on-going physical and psychological issues.

## Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit, and those close to them, in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude.

- People's privacy and dignity was maintained during episodes of physical or intimate care. Privacy curtains were drawn around people with appropriate explanations given prior to care being delivered.
- We spoke with the relatives of three patients. They were universal in their praise for the medical and nursing staff. They told us they had been kept informed of everything that was going on with their relative though one set of relatives reported that there had been a delay in speaking to a doctor about their relatives care and treatment.
- There was some discontent expressed by one family about the recent changes to the visiting times.

## Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so that, where possible, they understood their care and treatment.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- The unit was not using formal patient diaries. However, they did issue relatives with a notebook in which they could choose to document details of their relatives stay in critical care. These were usually issued after 48 hours, where appropriate. Usually used for patients who are sedated and ventilated, intensive care patient diaries are a simple but valuable tool in helping recovering patients come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- The unit carried out a monthly inpatient survey and the trust undertook a six monthly critical care relatives' survey. The sample size for the inpatient survey meant that the findings could not be said to be statistically significant, however the results were positive in respect of the care delivered. For the relatives six monthly survey for the period December 2015 to May 2016, the results were again very positive apart from some feedback on the levels of noise on the unit. As a consequence of this the unit had introduced a noise detector in the shape of an ear which changed colour in

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response to the ambient levels of noise in the unit. If the noise levels increased the colour of the ear changed from green to amber and then red. We noted that this device was laid flat on the nurses' station counter and therefore could not be easily seen.

## Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a senior nurse for organ donation available who worked closely with the critical care team in managing the sensitive issues related to approaching families to discuss the possibilities of organ donation.
- A follow up clinic for patients discharged from critical care was in place. The process started with a visit from the critical care outreach team once the patient had been discharged from critical care but remained a hospital in-patient. The outreach team was able to explain what had happened to the patient in critical care, to help them make sense of their experiences. In many cases this resolved any issues arising from the critical care admission and patients did not need or did not request to attend the follow up clinic. Those who were troubled or who wished to attend the follow up clinic after discharge were identified, and invited by letter to attend approximately 10-12 weeks after their discharge from hospital. During the clinic, the events of the patient's critical care stay and the context of their experiences were discussed. Physical symptoms were reviewed and specialist referrals made. For example, psychological symptoms were assessed to try and identify those patients likely to develop post-traumatic stress disorder. The follow up clinic was supported by rehabilitative physiotherapists, dieticians and psychology staff as well as the critical care outreach team.

## Are critical care services responsive?

Good



We rated critical care services as 'Good' for Responsive because;

- The trust had planned its critical care delivery in accordance with the needs of the local population.
- There was a critical care outreach service.

- Care plans demonstrated that people's individual needs were taken into consideration whilst delivering care and treatment.
- There were no instances of cancelled elective surgical cases as a consequence of there being no critical care bed, within the past four reported months.
- The numbers of delayed discharges was low when compared with similar units.

However,

- The data showed there was an issue with comparatively high numbers of out of hours discharges when compared with similar units.
- The number of non-clinical transfers out of the unit was slightly worse than similar units.

## Service planning and delivery to meet the needs of local people

- Until relatively recently Tameside General Hospital had also had a high dependency unit on the ground floor into which physicians and other specialities were able to directly refer. Due to changes in the hospitals case mix as a consequence of the Healthier Together Manchester programme, it was concluded that the trust only required nine critical cared beds to meet the needs of its patient population. Consequently the former HDU has now closed and the critical care unit operates as a 'closed' unit run by consultants with a particular interest in critical care.
- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.
- There were facilities for relatives to stay on the unit if they wished to and overnight, if needed.
- There was a critical care outreach team, providing a service seven days a week from 7.15am to 8.15pm. Funding had been obtained to expand the service for a trial six-month period and additional outreach staff were being employed. During the course of the inspection the outreach team was being led by the advanced critical care nurse practitioner. A middle grade doctor was also allocated to the outreach team on a daily basis.

## Meeting people's individual needs

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- Care plans demonstrated that people's individual needs were taken into consideration whilst delivering care and treatment.
- Interpreting services were available within the hospital if required and we saw them being utilised during our inspection.
- The critical care service had developed dementia champions and all staff undertook dementia training (e-learning) as part of their mandatory training subjects.
- Leaflets were available for patients about critical care services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients and relatives who had a visual impairment.
- There was a section in the relatives' waiting room that was screened off. The screens were obstructing the noticeboard making it difficult to read. The information on the noticeboard related to unit performance.
- Elective surgical admissions represented only 15% of the unit's case mix. The performance dashboard showed there had been no cancelled elective admissions in the last quarter as a consequence of there being no critical care bed.
- Total bed occupancy (level 3 and level 2) was reported as being between 87% and 94% for the months January to April 2016.
- For non-clinical transfers, the ICNARC data reported 8 (2.2%) for the period April 2015 to March 2016, which was slightly worse than for similar units (1.4%).

## Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns. These included defining who was responsible for managing complaints, the timescales for investigations and responses to complainants and the governance pathways through which complaints were reported from ward to board.
- Learning from complaints, concerns and compliments was triangulated within the division alongside other patient experience and feedback via multi-disciplinary and team meetings.
- The trust's website contained information on how to raise a concern both informally and as a formal complaint.
- The noticeboards in the critical care unit relative's rooms displayed a range of helpful and supportive information and contact details, including how to make a complaint or raise a concern.
- We did not see any specific critical care complaints data, although staff told us it was rare to receive a complaint. We did see a trust wide analysis of complaints received in May 2015 to the end of April 2016. The number of complaints (439) was slightly down on 2014/15 and when the complaints were analysed by department, critical care was not mentioned as one of the most complained about services.

There was a noticeboard on the unit corridor which displayed numerous thank you and compliments cards.

## Access and flow

- Patients were reviewed in person by a consultant within 12 hours of their admission.
- Looking at the most recently validated ICNARC data for the period April 2015 to March 2016, there was an issue with out of hours discharges. Out of hours discharges are defined as 'unit survivors discharged between 10pm and 6.59am'. For the reported period the numbers were relatively low at 20 but as a percentage of eligible admissions the rate was 7.4%. This performance was poorer than similar units (3.8%). This issue was also noted in the GMCCN report of May 2016 and the unit was recommended to undertake root cause analysis of any out of hours discharges.
- In terms of delayed discharges, for the same period the unit's performance was better than similar units. The percentage of bed days of care for patients for whom discharge had been agreed more than eight hours ago was 1.5% against 5.4% for similar units. The divisional performance dashboard also reported on delayed discharges and showed for March 2015, 16 patients delayed >4 hours and 2 patients delayed >24 hours. For April 2016 it there were 20 patients delayed >4 hours and 10 delayed >24 hours. We did note during the visit some data collection anomalies. For example the audit clerk responsible for managing the ICNARC data had not received any specific training.



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## Are critical care services well-led?

Good



We rated critical care services as 'good' for well-led because;

- There was an embedded and effective governance structure in place.
- There was clear and strong leadership at unit and divisional level with staff who had the skills, integrity, capacity and capability to lead the service effectively.
- There had been significant progress and improvement since the 2014 CQC inspection.
- Staff told us that they felt supported at work by their colleagues and were respected and valued. Managers were visible and approachable.

However,

- It was not clear from the divisional risk register what actions were being taken to mitigate to critical care risks.
- There were issues raised about the referrals to critical care from the physician led teams which did not always follow protocol.

### Vision and strategy for this service

- We saw a divisional service development strategy document for 2016 – 2018, which included a section for the directorate of theatres, anaesthetics, endoscopy and critical care. The only content that directly related to critical care was reference to the four hour target for admission, once a decision had been made to admit and a 24 hour target to discharge from critical care once a decision had been made to discharge. The discharge target as set out in the 2015 'Guidelines for the Provision of Intensive Care Services' is four hours from the decision to discharge.
- In the short term, the critical care service was going to move in the coming weeks to occupy the former HDU on the ground floor of the hospital whilst refurbishments to the first floor unit were undertaken. It was expected that the works would take about 12 weeks to complete. This move would reduce the bed capacity in critical care to a maximum of eight patients.

- There were plans to expand the outreach service and new staff had been recruited to enable a pilot to be undertaken.

### Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements and a pathway for reporting and escalation to the trust board.
- Critical care risks were included in the divisional risk register. The extract of the risk register that we saw was not that helpful in understanding the current risks in critical care. The entries relating to critical care were scattered throughout the 30 page document. Whilst each risk was assigned an owner and review date, it was not clear how long the risks had been on the register or what actions were being taken to mitigate the risk. In addition not all the risks were clear. For example risk number 3396 relating to critical care stated 'critical care services are not developed taking into account professional and expert advice as well as the needs of staff and patients'.
- A range of minuted meetings were regularly held including, mortality and morbidity meetings, critical care governance meetings, quality and safety meetings and unit review meetings.
- We saw a critical care dashboard which set out the performance of the service each month under a series of different areas. For example, cancelled operations, patient experience, finance, governance, infection prevention and activity and efficiency. This brought the unit's performance together in a clear to read and understand format.
- The unit was subject to annual peer review benchmarking by the Greater Manchester Critical Care Network against the present evidence base and agreed standards for critical care provision. The most recent review by the network had been in May 2016. The results of this last review showed high levels of compliance with the standards with only a few recommendations.

### Leadership of service

- The critical care unit had designated consultant and nurse matron clinical leads.

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- In addition the critical care areas were staffed and led by a team of experienced senior nurses.
- There was clear and strong leadership at unit and divisional level with staff who had the skills, integrity, capacity and capability to lead the service effectively. Senior managers were visible in critical care areas, leading and providing support to the teams.
- Considering the CQC rating from the 2014 inspection, where the critical care service had been judged as inadequate, it was clear that much progress had been made to improve the service provided to patients.

## Culture within the service

- Staff were open, honest and happy to tell us what it was like to work in critical care. They told us they were proud to work in critical care and recommended the trust as a place to work or receive care and treatment.
- Staff were encouraged to report incidents and raise concerns.
- During the course of the inspection we spoke with members of the critical care team including consultants, middle grade doctors, nursing staff and allied health professionals. A consistent theme emerged regarding the referral of patients from the physician led teams. Since the closure of the former high dependency unit, the physicians have nowhere to refer patients that require more care and closer monitoring than the ward is able to safely provide. So they are often referred to critical care and sometimes that referral is judged to be inappropriate for a number of reasons. We heard that the outreach team regularly receive around 10 referrals a day, approximately eight of which turn out not to be appropriate for admission to the unit. For example, patients at the end of life. The admission and escalation protocol for critical care states that admission should be via a consultant to consultant referral but staff stated that this did not always happen. Referrals were often made to the critical care team without the direct involvement of the consultant physician. We discussed what could be done to improve relationships and communication between teams. One initiative was being led by the middle grade doctors in the unit who

were reviewing all the referrals for admission and planned to share a presentation of their findings at 'grand rounds'. We raised this issue with the medical director of the trust during the inspection.

## Public engagement

- The trust website included details about the critical care service provided at Tameside General Hospital.
- On entering the unit corridor there was a display of helpful leaflets for relatives and friends.
- One of the noticeboard in the relatives' waiting room was obscured by a mobile screen making it difficult to read.







## Staff engagement

- Staff told us that they felt supported at work by their colleagues and were respected and valued. Managers were visible and approachable.
- There were numerous noticeboards on the unit corridor near the staff changing rooms and the seminar room that provided educational and supportive information for all staff. For example, learning from incidents and revalidation.
- The trust had 21 positive findings out of 34 indicators in the NHS staff survey with 11 findings within expectations and only two negative findings. They were for recognition and staff witnessing potentially harmful errors.

## Innovation, improvement and sustainability

- The trust had produced a quarterly 'Service Transformation Newsletter'. The first edition being published in May 2016. It was produced to share the learning from internal teams about their improvement journeys.
- The trust also produced a 'Learning from Experience' newsletter called 'Closing the Loop'. The newsletter aimed to capture areas of patient and staff safety, satisfaction and to share learning from incidents, complaints and audit across the organisation.
- The trust had recently been rated as outstanding for openness and transparency. Being positioned at number 8 in a national 'learning from mistakes league' published in March 2016 by NHS Improvement and the trust development authority (TDA).

# Maternity and gynaecology

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

## Information about the service

The trust offers pregnant women and their families antenatal, delivery and postnatal care at Tameside General Hospital. The department delivered 2280 babies from January 2015 to December 2015. A range of gynaecology services and termination of pregnancies are also provided.

The Women's unit occupies two floors of one wing of the hospital. There is a consultant led delivery suite with five birth rooms, one room with a birthing pool, one midwifery led care room and a bereavement room. There are also five recovery or observation rooms. There is no midwifery led birthing centre. The dedicated obstetric theatre was situated within the delivery suite. The single maternity ward has 28 beds used for either antenatal or postnatal care including 10 single rooms. At the time of the inspection the triage area of a day assessment unit of a four-bedded bay and two single rooms was due to be refurbished on the ground floor. The antenatal clinic is also on the ground floor of the women's unit was to be moved the following week whilst a full refurbishment of this area takes place.

There is a team of community midwives who cover the Tameside and Glossop area.

One ward of nine beds is specifically for gynaecology patients.

We visited the maternity department, day surgery unit, gynaecology ward and termination of pregnancy clinic during the announced inspection between 8 and 11 August 2016 and the unannounced inspection 18 August 2016. During our visits we spoke with 40 staff, eight patients and

two family members. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 12 patients. We also looked at five medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.



# Maternity and gynaecology

## Summary of findings

At the last inspection of maternity and gynaecology services in May 2014 the service was rated as good overall. They were rated as requires improvement in safe and good in effective, caring, responsive and well-led. Following this inspection those ratings remained the same.

- There was a system in place to investigate incidents and disseminate the lessons learnt.
- The necessary equipment was available, maintained within the requirements and had been checked in line with the trust's policy.
- There was a robust support system in place for patients with complex emotional, mental health or drug and alcohol problems.
- There was active midwifery recruitment which had filled the current vacancy rate.
- Staffing levels were appropriate to meet the needs of the patients in both maternity and gynaecology services.
- The consultant cover met the guidance for the number of births.
- Policies and procedures in maternity and gynaecology services were up to date and audited for their compliance with the relevant guidelines.
- The maternity service took part in national audits and there was a programme of local audits. Where actions were identified these were put in place and re-audits took place.
- Local audits for practices within the gynaecology and termination of pregnancy service had been completed.
- Most patient outcomes were in line with national or the trust's own targets. Where this was not the case measures for improvement had been put in place.
- There was good multi-disciplinary working between midwifery, nursing and medical staff and across other medical and surgical specialities.
- Consent for procedures in the maternity, gynaecology and termination of pregnancy services was accurately and clearly documented.
- We observed calm, patient, friendly and professional interactions between staff and patients in all areas of women's health.
- The trust scored better than the England average in six of seven questions about treatment during labour and birth.
- Patients and their supporters were involved in their own decisions and choices and kept informed throughout their care.
- Emotional support was offered and guidance of how to access other services was provided when required.
- The termination of pregnancy service was run to ensure patients could have additional support following their procedure should they need it. There was flexibility within the service delivery and staff responded to each patient's individual needs.
- The triage area of the maternity unit ensured patients could obtain prompt telephone advice and be seen in a timely manner.
- Whilst there was a lack of specialist midwives, those with a special interest had taken the lead to offer additional support to specific patients.
- The enhanced midwifery team provided consistent support and care for patients with social, emotional or mental health needs.
- A specialist programme for supporting and informing pregnant women with alcohol consumption problems had been developed.
- Systems were in place to learn from complaints.
- There was a clear vision and strategy for the service which incorporated regional and national developments.
- Governance processes in place included oversight at trust, divisional and local level with resulting plans and actions reviewed through a robust process.
- The risk management process meant there was local ownership for risks with overarching management at a divisional level.
- Staff were complimentary about the leadership of the service saying they had approachable, visible and knowledgeable managers.
- There was an open culture where staff felt enabled to discuss any concerns or ideas.
- Mechanisms were in place for staff and patient engagement and involvement in service development.
- There was a focus on improvement and sustainability both within the service and the wider health economy.

# Maternity and gynaecology

However:

- There were infection prevention and control concerns on ward 27. These were brought to the attention of the managers during the inspection and at the unannounced inspection; improvements had been made with plans in place for further actions.
- Emergency medicines were not safely stored in the obstetric theatre.
- Records were not securely held in the maternity and gynaecology wards.
- Mandatory training within the maternity services did not meet the trust's target in five of the nine specific units and ward areas.
- Assessments to identify a deteriorating patient were not accurately completed on the maternity unit or the gynaecology unit. The escalation of such patients had not taken place as per the trust's policy. Managers were aware of this and action was being taken to make improvements.
- The safer surgery checklists were not fully completed for maternity surgical procedures. Managers were aware of this and actions for improvement were in place.
- There was no formal system for the exchange of information, including required visits, for the community midwifery teams. This was under review at the time of the inspection with the appointment of a new manager.
- Inpatient beds on the gynaecology ward were used for patients from other specialities. Whilst this led to cancelled procedures they were rebooked within the required timescale.

## Are maternity and gynaecology services safe?

Requires improvement



We have rated maternity and gynaecology services as requires improvement in safe because:

- Some of the environment and equipment on ward 27 did not meet infection prevention and control standards. Action had been taken at the unannounced inspection with further work planned.
- On ward 27 not all areas which should be inaccessible to patients were secure.
- The procedure used by anaesthetists to prepare emergency medicines in the obstetric theatre did not meet the safe management of medicines guidance.
- Patient records were not securely stored on the gynaecology inpatient ward or ward 27.
- There was no robust system for the allocation or reallocation of community midwives visits.
- There was no system for monitoring missed appointments by community midwives.
- Not all staff were up to date with mandatory training. The lowest compliance was in health and safety and infection prevention and compliance.
- In three of the nine areas of the maternity services, staff were not up to date with children's safeguarding training.
- On ward 27 and the gynaecology unit risk assessments to identify deteriorating patients were incomplete, not recorded within the expected timescales and risks that were identified were not escalated according to the trust's policy.
- An audit of the World Health Organisations safer surgery checklists showed they were not fully completed

However:

- There was a system in place to investigate incidents and disseminate any lessons learnt.
- The necessary equipment was available, maintained within the requirements and had been checked in line with the trust's policy.
- Medicines were safely stored, administered, recorded and disposed of in ward areas.

# Maternity and gynaecology

- There was a robust support system in place for patients with complex emotional, mental health or drug and alcohol problems.
- There was active midwifery recruitment which had filled the current vacancy rate.
- Staffing levels were appropriate to meet the needs of the patients in both maternity and gynaecology services.
- The consultant cover met the guidance for the number of births at the trust.

## Incidents

- There were 580 incidents in the maternity and gynaecology services between June 2015 and May 2016. 91.8% of these resulted in no harm.
- Most of the incidents, 49% were related to scans, x-rays and specimens which were mislabelled or unlabelled. All of the incidents reported in this category resulted in no harm. Investigations into this theme of incidents had shown there was a coding issue which should be resolved.
- A 72 hour review of all incidents had been introduced. This was to evaluate the level of harm and agree the necessary actions for investigation.
- Following any serious incidents a rapid review would take place to establish any immediate actions to prevent recurrence.
- Established systems for investigating incidents were used where indicated. This included the perinatal institute investigations for neonatal deaths.
- Where applicable joint investigations into incidents took place. This included with other services such as mental health and with other trusts as required.
- A monthly multidisciplinary meeting with paediatrics and maternity services took place to review any admissions to the neonatal intensive care unit of term babies. Any issues or themes were discussed and actions taken.
- All incidents were discussed at the monthly obstetrics and gynaecology governance meetings. These were multidisciplinary meetings were serious incidents or any themes in incident reporting were discussed and actions agreed.
- There were systems in place to encourage learning from incidents. This included feedback for the reporter of the incident, inclusion in the printed “closing the loop” newsletter, learning from experience forums and a standing agenda item for ward meetings.
- Learning from serious incidents took place. Examples included the development of a passport for patients with a learning disability to ensure all staff understood their communication abilities and their mental capacity to understand and retain information.
- Monthly perinatal morbidity and mortality meetings were attended by the consultants, junior doctors and nursing and midwifery colleagues from obstetrics and paediatrics. Any cases were presented and lessons learnt were disseminated via the obstetric and paediatric governance meetings.
- Any gynaecology mortality reviews would be included in the trust’s monthly mortality steering group meetings.

## Safety thermometer

- The safety thermometer was displayed in the gynaecology inpatient ward. The previous three months was on display as a comparison. This showed there had been no harm and nine compliments.
- Data for the maternity specific safety thermometer was being captured as part of the maternity dashboard information. Staff were aware of the data and it was used during ward meetings to discuss patient outcomes.

## Cleanliness, infection control and hygiene

- Quarterly infection prevention and control audits were completed and ward 27 had scored 83% in April 2016. This meant actions should have been taken and the ward re-audited. However we found issues which had not been identified or rectified following the ward audits. These included scuffed wooden surfaces, doorways and equipment which could not be thoroughly cleaned, tears in a seat cover, chipped paint and loose plaster, rusty waste bins and a perished area on a cot mattress. At the unannounced inspection a more thorough audit had been completed and some items had been removed or replaced. A programme of deep cleaning refurbishment was planned.
- We found the delivery suite to be visibly clean. This area scored 94% on the quarterly infection prevention audit completed in April 2016.
- There had been no cases of MRSA or Clostridium Difficile in maternity services for the past 12 months.
- Whilst waste was appropriately segregated on all wards there was a very large clinical waste bin in the dirty utility room of ward 27. It was confirmed this should not be there and would be re-sited.

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- The waste collection facilities on the central delivery suite were clean and met the relevant guidance.
- Hand wash facilities were situated in the ward areas and hand gel was available at the entrance to each ward and treatment area.
- All maternity areas had scored 100% in hand hygiene and bare below the elbow audits in May 2016.
- The daily cleaning checklist in the gynaecology inpatient ward had not been completed on a daily basis. Week commencing 25 July 2016 it was blank on two days and week commencing 1 August 2016 it was blank on three consecutive days. This cleaning included infection prevention measures such as cleaning patient areas and equipment. The area was visibly clean and tidy.

## Environment and equipment

- All resuscitation equipment in the maternity and gynaecology departments had daily checks recorded.
- The difficult airway trolley in the obstetric theatre had not been checked on 6 August 2016 although all other checks on the records we reviewed had been completed.
- Some new equipment had been purchased in the past 12 months on the maternity unit which included resuscitaires and monitoring equipment.
- All equipment on the gynaecology inpatient ward had been serviced within the required timescales and had up to date stickers attached for reference.
- All portable electrical equipment we saw had been tested.
- Should equipment on both the maternity unit and the gynaecology ward need to be repaired this was done quickly, including if external engineers were required.
- The gynaecology day surgery unit was moving to a new area the week after the inspection. At the unannounced inspection we saw this had taken place. All necessary equipment was in the new environment and there were advantages in the environment such as a larger waiting area with facilities for private consultations, closer to theatres, situated with other day surgery units for support from staff and doctors if required and a discharge lounge facility.
- The antenatal clinic area was being relocated the week after the inspection to allow for a total refurbishment of the area. This included changes to the layout, new equipment, and replacement of all fixtures, furniture

and flooring. The plans for this were on display and patients had been informed of the clinic relocation. Due to this the existing clinic area was not reviewed at this inspection.

- There were four outpatient treatment rooms specifically used for gynaecology procedures. These had private changing and showering areas for patients.
- Doors to staff only rooms on ward 27 were not secure. The dirty utility room was accessible at all times as there was no locking mechanism to secure the door. The door to the domestic cupboard had a keypad which was not working therefore there was access for patients.
- There was no dedicated second obstetric theatre. In an emergency an available theatre in the general theatre suite would be used. The journey to the main theatres from delivery suite was a six minute walk which involved going up a sloping corridor. It was discussed this was difficult with the equipment required as well as the patient and bed. This had occurred three times in the past 12 months. The senior management team were discussing the available options to change the current arrangement.
- A bereavement room was available which included a sitting area with kitchenette where parents could stay if they wished.
- Although partners were able to stay with a patient on the maternity ward there were no bathroom facilities for them.
- An additional ultrasound scan had been purchased to assist with the increased number of scans due to the SABINE (Saving babies lives in the North of England) programme. This is an NHS funded initiative to assist with the implementation of the Growth Assessment Protocol (GAP) as a part of the NHS Care Bundle. Additional scan activity is created as a result.

## Medicines

- Medicines were safely stored in all areas including controlled drugs and intravenous fluids.
- Controlled drugs records were accurately completed including the daily check of stock.
- The medicine fridge temperatures had been checked and recorded on a daily basis. This record had changed between the announced and unannounced inspection with a new record of maximum and minimum temperatures recorded.

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- Epidural wastage was recorded and this was audited by the delivery suite manager. There had been three episodes of non-compliance and actions had been taken to address this with individual staff and inform the wider staff team.
- The stock of medicines patients may require on discharge had been increased with the guidance of the pharmacy department. This reduced the possibility of delays due to not having the required medicines available.
- The maternity wards had a dedicated pharmacist who visited most days to check the stock and provide guidance if required.
- The trust's policy for the safe use of emergency medicines in the obstetric theatres was not being followed by all consultant anaesthetists. We observed medicines which were made ready for use by one anaesthetist, including handwritten labels, were then handed over to another anaesthetist at shift changeover. This was discussed at the anaesthetics directorate meeting on 19 July 2016 where it was agreed a review of the emergency maternity medicines management would be completed within one week. We were told the outcome of this was that the medicines should be prepared only by the anaesthetist on duty and not made ready by another. This was brought to the attention of the managers during the inspection.
- In September 2016 additional midwives were booked on training to administer intravenous antibiotics to babies. This would reduce the need for paediatric staff to complete this task and ensure the timely administration of these medicines.
- There had been five medicine administration errors in the previous month which had been reported as incidents. Lessons learnt were shared and remedial action taken with individual staff when appropriate.
- Risk assessments and procedures were in place for the safe provision of medicines, including medical gases, for home births.
- On the gynaecology inpatient ward the trolley which contained patient notes was open and accessible to patients and the general public.
- In the termination of pregnancy clinic the patient notes were in a secure area with staff present during the clinic.
- On the maternity ward and delivery suite the patient information boards met confidentiality of information guidance.
- The records we reviewed had care plans which had been completed, reviewed and were up to date.
- The patient hand held notes were being reviewed and would change from the perinatal institute notes to ones developed by the trust. A multidisciplinary working party was completing this work and the first draft of the intrapartum records had been completed.
- Infant health record books were issued to patients.
- Telephone calls to the triage area were recorded in detail. This included the personal information, the reason for the call, information provided to the patient and any other pertinent details such as safeguarding issues.

## Safeguarding

- 96% of midwives had completed safeguarding training to level 3. This had become mandatory for all staff in 2016 and training was planned so that it would be completed for all those who required it by December 2016.
- 98% of staff in the maternity and gynaecology services had completed children's safeguarding training. However, staff in the central delivery suite, antenatal unit and the community midwifery team were below the 95% trust target.
- The system to record a safeguarding alert on a babies' record varied between the maternity unit system and that in the emergency department. A process was in place to ensure that any alert was identified on both systems in case a baby returned to the emergency department soon after discharge.
- The chaperone policy was displayed in the gynaecology outpatient areas and support was available for those patients who required a chaperone.
- The enhanced community midwifery team consisted of five midwives. They provided continuous antenatal and post natal care to young patients, those with mental health needs or child protection concerns.

## Records

- The storage of notes on ward 27 was not secure. Patient medical files were on the desks at the care station in the centre of the ward and the office behind this desk had many open boxes of patient notes and full unlocked filing cabinets. Whilst at busy times staff were around this area there were times when staff were not present and the door to the office was open.



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- Patients were seen by the enhanced midwives without their partners at least twice in the antenatal period to enable them to discuss any issues of domestic violence.
- The system for ensuring the safety of patients who did not attend community appointments was not robust. There had been a non-attendance on the day of our inspection and the specific midwife emailed the rest of the team and one of whom would then let them know they would follow up the visit. As the midwife involved was not working the following day they would have to ensure, in their own time, that the visit had been completed by a colleague.
- Between 4 July 2016 and 10 August 2016 there were 10 missed community midwife visits and one duplicate visit. Midwives had not completed incident forms for these; however the community midwife manager was now doing so. These missed visits would be investigated. Patients were informed to contact the community midwives office if their visit was missed and this would be reallocated.
- Multi-agency discharge planning meetings took place for any patient where safeguarding concerns had been identified. This included those with mental health, drug and alcohol or social concerns where additional support may be necessary.
- The fridge for the storage of expressed breast milk was in the patient's kitchen. This was accessible to all patients and their partners at all times. Tamper proof lids were used on the bottles; however the managers agreed there was a lack of assurance that this milk was secure. On the second day of the inspection this fridge had been moved to a secure room.
- There was secure intercom and video access at the entrances and exits of the maternity wards and central delivery suite.
- One consultant obstetrician led on female genital mutilation and had provided training for the medical staff as part of a governance meeting. They worked closely with the safeguarding lead midwife to provide support for any doctor who may need to report a case and not feel confident to do so.
- We observed staff in the termination of pregnancy clinic understood the need to ensure the patient was not coerced in their decision making by a third party. This was sensitively approached as part of the initial consultation with the clinic nurse.
- There had been no infant abduction simulation exercise. A tabletop exercise took place in March 2015.

## Mandatory training

- The practice development midwife did not monitor the overall training statistics for staff or report attendance at the governance meetings. The obstetric lead kept the data for the doctors training. This meant up to date figures specific to the maternity and gynaecology wards could not be provided for either trust wide mandatory training or maternity specific training.
- 95% of medical, nursing and midwifery staff in the women's services division was up to date with the mandatory training. However, 85.2% of staff were up to date with infection prevention and control.
- The maternity specific day of mandatory training was multidisciplinary. All midwives, obstetric doctors, midwifery support workers and neonatal staff were allocated training dates at the beginning of the year. The anaesthetists and paediatricians were not included.
- The basic life support training did not include a simulation of using the equipment available or familiarisation with the contents of the resuscitation boxes. This meant not all staff had received training which would ensure they could respond effectively nor in a timely way should this equipment be needed.
- The mandatory training programme included updates on documentation, governance and bereavement care.
- Skills and drills training was included on day two of the mandatory training. This consisted of work stations facilitated by senior staff where midwives and doctors practised their skills. This included emergency drills and neonatal resuscitation.
- Doctors new to the department reported thorough and supportive induction training had been provided.

## Assessing and responding to patient risk

- Risk assessments such as the Malnutrition Universal Screening Tool (MUST) and VTE (venous thromboembolism) had been completed for patients in the gynaecology ward.
- We reviewed four early warning score (EWS) records on the gynaecology inpatient ward. None had been completed in line with the trust policy which was that if a patient scored between one and four they should be rechecked within 30 minutes. For one patient whose score had been two at 8.20am there was nothing documented until 5pm when they were "off the ward".

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For another whom scored two at 8.15am and it was written it was to be checked in six hours the next documented entry was 9.20pm This was brought to the attention of the manager at the time of the inspection.

- We reviewed four patients' early warning score records on the maternity ward. None of these had been completed in line with the trust's policy. The total score had not been added up on every occasion the observations had been recorded.
- For two patients on the maternity ward who had one red score the doctor had not been informed which was not in line with the trust's policy. Senior midwives told us they used their professional judgement to call for medical assessment rather than followed the policy.
- There was a record in one patient's notes that the doctor was aware; however, there was no documented plan or direction for care. We were told this should have been the procedure for such a patient.
- The discrepancies we found in recording and escalating patients' deteriorating condition in line with the trust's policy was brought to the attention of the ward manager. They were aware of these issues and had instigated daily record audits on five charts per day and had discussions with staff that did not follow the policy. Staff performance would be escalated if there was no improvement.
- We saw the results of these audits for four days. Incorrect use of the EWS included not all parameters being completed and a patients' condition not escalated when their score showed their condition had deteriorated.
- There was no guidance on the early warning score record of how frequently this should be completed if a patients' score increased which indicated a deterioration in their condition. Midwives were unaware if this was in a policy; however, they told us how frequently they would complete them, which was not consistent amongst all staff.
- There was prompt follow up by community midwives following patients' contacting them or being seen with concerns and at the start of labour.
- We saw documentation that the trust's policy of "fresh eyes" (the practice of two competent practitioners reviewing a CTG trace) had been followed during labour.
- A delay in a doctor attending a patient on the delivery suite had been appropriately escalated.
- An audit of the WHO checklist had been carried out in June 2016. This showed a 6% compliance overall. As a

result the form had been changed and a re-audit in July 2016 showed 50% compliance. Further work was underway to define roles in the completion of the checklist post procedure.

- The World Health Organisation (WHO) surgical safety checklist had been completed in the records we reviewed including gynaecology patients.
- An intensive care outreach team was available for support and advice if there were any concerns about a patient's condition.
- There was no post-partum haemorrhage emergency drugs box. Staff told us they gathered the medicines they required when needed in an emergency.
- Emergency evacuation of a patient from the birthing pool had taken place within the hospital in April 2016 and in the home environment in May 2016.

## Midwifery staffing

- A review of midwifery staffing numbers had been undertaken in January 2016 using Birth-rate plus criteria and calculation tool, in line with the NICE guidance for Safe Midwifery Staffing for Maternity Settings (NICE, 2015). This identified a growing number of births with impact on the required number of midwives which was to be monitored via the maternity dashboard. The workforce section of the dashboard provided by the trust contained no data.
- A meeting of the managers of the various maternity departments took place at 8.15am every day. At this time the activity in each area was discussed, including any planned or expected emergency admissions. The staffing for each area was reviewed and if necessary staff were moved to ensure there was adequate cover, including skill mix, for the activity.
- We saw when midwife numbers were below those planned for a shift additional staff were in place. During our inspection we saw when there should have been six midwives and there were five there was an additional theatre scrub midwife and one health care assistant on duty.
- Recruitment of midwives was not difficult for the trust. 13 midwives which represented 9.7 whole time equivalent midwives had been recruited to start work between August and October 2016. This would meet the vacancy rate of 9.8 full time posts.
- There were no nursing vacancies in the gynaecology department.



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- The midwife to birth ratio had been 1:30 in June but had improved to 1:28 with new midwives starting employment.
- We were told one to one care in labour was achieved.
- Two midwives were on call to assist at any home births out of hours.
- There was one midwife and one maternity support worker on the ante-natal day assessment unit which had 10 to 12 patients per day. Staff told us this was usually sufficient.
- A new manager for the community midwives had been appointed in June 2016. The current systems of working were under review and a new model was being considered.
- Community midwives and the community midwife manager were unable to tell us how many patients they had on their caseload. Therefore there was no management of the equity or suitability of the size of community caseload. During the inspection one midwife had accepted seven visits which they could not complete. Managers were aware of this and a scoping exercise had begun.
- A hospital manager was available on site or on call 24 hours per day and a supervisor of midwives was on call out of hours to provide support if required.
- The labour ward coordinator was responsible for monitoring any shortage of staff and capacity issues out of hours. The escalation policy was to contact the manager on call, the supervisor of midwives and if they felt staffing levels were unsafe and the unit should close the executive on call. We were told the executive team were very supportive if the coordinator made a request to close the unit.
- In order to maintain a skilled workforce a positive approach to retiring and returning to work with reduced hours was in place. This included the opportunity for staff members to reapply for a part-time post following retirement and 12 staff had taken this up.
- Three assistant practitioners were employed to work on the maternity ward with one on duty seven days per week. They were described by midwives as an “asset” to the team. They had completed training and competence assessments to care for post natal patients including completing a patient’s discharge.
- Maternity support workers were currently a band 2 however, there were plans to develop more band 3 assistant practitioners.
- The annual midwifery staffing rotation was under review. Staff had been asked which area they would like to work which will be accommodated where possible. The plan was to have core staff in some areas with a smaller group who rotate. Some staff had been working in one area for 3 years; however there would be no compulsory rotation.
- We saw documentation that midwives had offered apologies when they were busy and felt they may not have seen patients in a timely manner.
- On the maternity ward shift handover was recorded and included any incidents and the theme of the month, which was currently the completion of EWS.
- There was a midwife from the enhanced team based in the hospital Monday to Friday 9am to 5pm and one on call in the community. Out of these hours safeguarding support was provided by the on call supervisor or the children’s safeguarding team.
- Midwifery led care was available from a specific team of midwives who were based on the delivery suite and managed low risk patients. They would attend midwifery led births on delivery suite and home births. They would be supported by the on call community midwife at a home birth. This team had one whole time and one part time vacancy.
- There was no audit of the NICE midwifery staffing red flags although staff told us these were used to raise staffing concerns.
- There was a multidisciplinary handover at 9am and 5pm daily on the delivery suite.
- Nurse staffing on the gynaecology ward was displayed at the entrance. This showed they were one registered nurse below the required number; however an advanced practitioner was on duty to replace them.
- Five band 5 registered nurses had recently been recruited to work on the gynaecology ward. Four had started work at the time of the inspection.
- There was pre-operative gynaecology nurse on duty Monday to Friday 9am to 5pm.
- A two year course for an advanced nurse practitioner for gynaecology services had been funded by the trust. Interviews for interested staff members had taken place the week before the inspection.
- There was a trainee advanced practitioner for women’s health who would start the course in September 2016 and would work on the emergency gynaecology and the early pregnancy units.

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## Medical staffing

- There were 60 consultant obstetrician hours per week which met the guidance for the number of births. This included consultant ward rounds on Saturdays and Sundays.
- Consultants provided on call cover out of hours for one week of every seven. Two doctors were responsible for ensuring the rota was covered.
- There were five obstetric medical vacancies and no full time vacancies in the gynaecology department.
- The average locum usage in obstetrics and gynaecology was 12.3% between May 2015 and May 2016. No long term locum doctors were used and when locum doctors were used they were regular and provided consistent care.
- When needed consultants worked in place of vacant junior grades to ensure the medical staffing levels were appropriate.
- A consultant anaesthetist was on duty from 8am to 6pm seven days per week. Out of these hours an anaesthetic registrar was on call specifically for obstetrics and gynaecology with a consultant on call.
- Doctors had a medical handover at 9am, 1pm and 5pm. The delivery suite co-ordinator attended these handovers. We observed junior doctors to be present during the midwives handover; however they did not participate in the discussions.

## Major incident awareness and training

- Staff members were aware of their responsibilities dependent on their position in the event of a major incident. Those we spoke with had not been part of a training exercise regardless of their years of service.

## Are maternity and gynaecology services effective?

Good



We rated maternity and gynaecology services as good in effective because:

- Policies and procedures in maternity and gynaecology services were up to date and audited for their compliance with the relevant guidelines.

- The maternity service took part in national audits and there was a programme of local audits. Where actions were identified these were put in place and re-audits took place.
- Local audits for practices within the gynaecology and termination of pregnancy service had been completed.
- Pain relief was prescribed and administered in a timely way in both gynaecology and maternity services, with effectiveness monitored.
- Patients received support for their choice of infant feeding. The service had achieved UNICEF UK Baby Friendly stage 3.
- The maternity dashboard contained comprehensive information which was used to monitor patient outcomes. This was in the process of being developed to include targets and risk ratings.
- Most patient outcomes were in line with national or the trust's own targets. Where this was not the case measures for improvement had been put in place.
- Staff of all grades had their competence assessed in a variety of maternity practices and procedures throughout a 12 month period.
- There was good multi-disciplinary working between midwifery, nursing and medical staff and across other medical and surgical specialities.
- Consent for procedures in the maternity, gynaecology and termination of pregnancy services was accurately and clearly documented.
- Staff were aware of their responsibilities within the mental capacity act and deprivation of liberty safeguards.

However:

- The revised maternity dashboard did not contain targets and was not risk rated.
- There was no formal system for the exchange of information, including required visits, for the community midwifery teams.

## Evidence-based care and treatment

- A baseline assessment of compliance with NICE (National Institute for Clinical Excellence) guideline on intrapartum care (CG190) had been completed. 92% of the guidance was met and actions were put in place to meet the outstanding recommendations.
- Assessments had been completed for compliance with relevant speciality quality standards on the maternity unit. These included the quality standard for maternal

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and child nutrition (QS105), diabetes in pregnancy (QS109) and for antenatal and post natal mental health (QS115). Where noncompliance was identified actions were taken for example changes to the parent and infant mental health care pathway.

- Where possible regional maternity forum guidelines were used.
- A guideline for small for gestational age babies was in place which included a four weekly scan schedule.
- A guideline which incorporated the Obstetric Anaesthetic Standards produced by the AAGBI (Association of Anaesthetists of Great Britain and Ireland) had been produced by the anaesthetic department. This was scheduled for audit and incorporated into the 2016/17 audit plan for anaesthetics.
- The system for the review of guidelines was to remind the responsible person by email 90 days prior to the review date. Once completed these were then passed to the junior doctors and midwives and responsible governance team members for review and comment. Once completed they were ratified at the governance team meeting.
- The trust participated in several national maternity audits including the national annual FASP (Fetal Anomaly Screening Programme) audit, the quarterly national antenatal and new-born screening KPI submissions and the quarterly Health Protection Agency Infectious Diseases audit.
- An obstetric local audit programme was in place. We saw where these audits had identified concerns or non-compliance with policies or procedures further actions had been taken. This included the WHO checklist audit and the early warning score audits. Re-audits were completed once actions had been taken to monitor improvements.
- Audits completed in the maternity service were shared with other services in the trust. This was through dissemination via presentations to all medical staff, laminated posters and discussion at clinical professional development meetings.
- An evidence based practice group had been established to identify new practice and understand research behind changes in care and support.

- The development of an enhanced recovery pathway for patients following a caesarean section was underway. Currently patients were reviewed and if appropriate discharged within 24 hours of delivery; however this was not part of recognised care pathway.
- A failsafe system was in place to monitor women's acceptance of first trimester screening. Where this was initially declined it would be offered again at following appointments. Data was reported to the national screening committee as required.
- There was 95% compliance with the 72 hour standard for new-born infant physical examinations.
- The termination of pregnancy service met the relevant guidance in terms of time from decision to procedure.
- An audit of patients returning to the service following a termination of pregnancy had been completed. This had shown a 10% return rate and as a result antibiotics had been prescribed which had reduced the numbers of patients who returned.
- Contraceptive advice was provided to all patients who had a termination of pregnancy. Patients could have contraceptive implants at the clinic following their procedure should they wish.
- As part of the MAMA project the alcohol consumption audit tool had been reviewed and found to be unrealistic for pregnant women. The lead of this project had developed a modified audit tool funded by public health.
- There was no policy for the transfer of patients from a low risk to a high risk care pathway. Staff were aware of what treatment would result in a move from midwifery led care to consultant led care.

## Pain relief

- Patients having gynaecology procedures were prescribed pain relief prior to their surgery in case they needed it post operation. This included oral and injectable medicines.
- For one gynaecology patient we saw a referral to the pain management team had been made when they had pain which was not easily managed.
- There was one bath available on the maternity ward. This would be used for pain relief if required.
- Maternity patients who required a caesarean section had anticipatory pain relief prescribed prior to the procedure. This meant there was no delay in this being administered if required.

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- A 24-hour epidural service was available on the delivery suite. There were no reported delays in receiving an epidural due to the availability of anaesthetic cover.
- Community midwives had access to pain relief for home births including medical gases.
- There was clear documentation of when patients had been offered pain relief and had refused. Patients had been offered alternatives such as massage and it was documented if this had been accepted and the effectiveness.
- Patients having a termination of pregnancy were prescribed pain relief as routine. Staff had a good understanding of the level of pain which a patient may suffer and any patient could remain in the unit until they felt able to leave.

## Nutrition and hydration

- The service had attained baby friendly status level 3. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and were supported in their chosen feeding method.
- In March 2017 a joint assessment of inpatient and community services would take place as part of the integrated pathway.
- There had been a shortage of infant feeding midwives with the ward manager having been in that role previously. From September 2016 there would be two infant feeding midwives on the ward.
- The ward manager was also the infant feeding coordinator and ran the frenulotomy clinic which is the removal of a small fold of tissue in the mouth, which restricts infant feeding, to treat tongue-tie. Due to changes to their post this clinic had become less frequent and there was a one to two week wait for an appointment.
- It had been recognised that some patients were unable to continue successfully expressing breast milk on their return home. The trust had purchased breast pumps for patients to take home for an agreed period. These were the same model as used in the ward to assist with continuity for patients.
- Patients told us they had good support from the midwives to breast feed their babies; however they did not feel pressured to adopt this method of feeding. Those choosing infant formulae milk also received support and guidance.

- On the maternity ward, there was a patients' kitchen where patients and partners could make hot and cold drinks and snacks.
- Meals for patients with special requirements were available. This included for dietary or cultural purposes.
- Snack boxes were available for parents out of hours and hot meals were available 8am to 8pm.

## Patient outcomes

- The maternity dashboard contained information about the outcomes for patients. The format of the dashboard had been revised to rationalise it and ensure it was aligned with the Strategic Clinical Network requirements. There were additional local items aligned to the outcomes for the patient safety work stream programme and maternity safety thermometer data.
- The data on the revised dashboard from April 2016 to June 2016 was presented numerically and not as a percentage of the total. Therefore some of this up to date information could not be represented in this report as it could not be compared to the figures for 2015 to 2016. Also the data could not be compared to any targets as they were not documented in the new format.
- The midwifery leads and clinical directors told us they used this information for a month on month comparison of data. Should an area of concern be noted a review of practice would be completed.
- The implementation of SABINE had resulted in a reduction in the number of stillbirths. This programme had led to 11,000 extra scans being completed between January 2015 and June 2016.
- The number of post-partum haemorrhages was above the trust's target for three of the 12 months April 2015 to March 2016. The measure for this had increased on the new dashboard from 1.5litres to 2.5litres to meet Royal College of Obstetrics and Gynaecology guidance.
- The number of patients who received one to one care in labour was recorded on the updated dashboard for April 2016 to June 2016. Although staff told us they did achieve one to one care in labour the total number did not equal the number of live births.
- Data for admissions from obstetrics to the intensive care unit were included on the dashboard for four of the 12 months and was above the target of one patient for three of these months.
- Where concerns about patient outcomes were identified action was taken. One example was the trust had been

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identified as an outlier for third degree tears and as a result a review of cases had been completed. This identified an issue in using the correct identification code and not a practice issue. This had been above the trust's target for five of 12 months from April 2015 to March 2016.

- A local authority funded smoking cessation midwife was employed at the trust. Smoking during pregnancy had decreased from 17% between April 2015 and April 2016 to 14% between April and June 2016.
- There were a maximum of three inductions per day unless a patient required an unplanned induction for the safety of their baby. Those booked were rarely delayed.
- Surgical site infection data for patients following a gynaecology procedure was not routinely collected. It was acknowledged this information should be accessible as any patient returning should be reported as an incident; however the lack of data collection meant it was not currently measured. A review of these patients had begun.
- A pathway for patients who attended the emergency department during early pregnancy had been developed. Staff in the emergency department told us this was used to ensure these patients were transferred to midwifery care as soon as possible.
- A clinical review tool was to be implemented to standardise clinical reviews of unexpected poor outcomes.
- There were 46 home births between April 2015 and June 2016. On all but one month the percentage of home births met the trust's target.

## Competent staff

- 88% of nursing and midwifery staff in the women's services division had completed their appraisal between April 2015 and March 2016.
- At the last local supervising authority audit in August 2015 all midwives were allocated a supervisor of midwives and the ratio met their recommendations of 1:12. Managers confirmed this remained the same.
- The practice development midwife had completed the preparation of supervision of midwives course and was waiting to be appointed by the local supervising authority as a supervisor of midwives. They were also one of the trust's manual handling coordinators and one of the PREVENT trainers for the trust. (PREVENT is a strategy to identify and reduce the risk of radicalisation).

- Midwives had assessments of their competence to complete and interpret cardiotography (CTG) records as part of a recognised training package. It was included in their appraisal that they had to complete five simulated exercises. This was included as part of the consultants annual appraisal.
- To aid the competence with CTG interpretation these were reviewed at specific meetings and shift handovers where multidisciplinary discussions could take place.
- There were core staff who remained working in a specific area of maternity services who therefore had the expertise in that area. There were then staff who rotated between areas such as community and inpatient wards to keep up their skills.
- There were 33 midwives who had not assisted in a birth for the past 12 months. Although they were included in the escalation policy for staffing the implementation of this policy meant they would not be asked to work in a birth environment if they did not have recent experience.
- One midwife sonographer was in post with a further two being trained.
- Midwives provided scrub assistance in the obstetric theatres. They had not completed formal training or had competence assessments for this role. From October 2016 a theatre scrub nurse would be available two days per week to provide cover for both emergency and elective caesarean sections. From February 2017 the general theatre management would take full responsibility for the requirements of this role.
- Band 5 midwives were assessed for their competence in the administration of medicines. They would be supported to improve their practice with the help of the supervisor of midwives if applicable.
- There was an experienced screening midwife in post and a job description was out for approval for a deputy. A midwifery support worker assisted with data entry and failsafe monitoring.
- The safeguarding lead midwife received supervision of her practice externally from the lead nurse at the Clinical Commissioning Group (CCG). They then provided support and supervision to the other midwives in the enhanced midwifery team.
- The enhanced midwifery team were completing training in November to provide safeguarding supervision to the other midwives.



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- The blood transfusion team had provided training to staff in the correct procedures to follow to ensure traceability of blood products.
- In January 2017 five staff members including two midwives, one obstetrician and one anaesthetist would attend a PROMPT training course. This is PRactical Obstetric Multi-Professional Training.
- Two trust wide training drills had been completed where staff from the maternity unit had attended. In November 2015 this was for sepsis management and July 2015 for eclampsia. Ward based scenario training included post-partum haemorrhage management on ward 27 and shoulder dystocia on the central delivery suite.
- A two year preceptorship package was in place for midwives. There was a minimum competence required in some elements of training prior to progression to a band 6. This included intravenous therapy and perineal suturing. These midwives rotated round the various maternity units spending a minimum of six months in each.
- Newly appointed experienced midwives had an induction which included a trust wide induction and being supernumerary in each area of the maternity services.
- There was one midwife sonographer and two more were being trained.

## Multidisciplinary working

- Both midwives and doctors of all grades described good team working. They discussed how both could raise questions and concerns with each other and worked collaboratively to ensure the best care for patients.
- We observed effective multidisciplinary working between specialities with doctors from a medical speciality visiting the ward and offering advice and support with a patients' management.
- We spoke to doctors who had very recently started work in the hospital. They told us they had been very well supported by staff of all grades and everyone had been very welcoming.
- There were specialist antenatal clinics for patients with medical issues. These included for diabetic patients were a specialist doctor; diabetic specialist nurse and obstetrician were present. There was no dietician to attend this clinic.
- A consultant obstetrician with an interest in perinatal mental health held a specific clinic and can refer to a perinatal psychiatrist for support. There was a

multidisciplinary meeting where these patients' needs would be discussed. The manager of the enhanced midwives team, consultant obstetrician and psychiatric professionals attended.

- There was good support from the paediatricians when this was required. They attended births where there were identified risks and would attend to provide support when needed.
- Where patients needed to be transferred to other units due to medical concerns there were systems in place for the exchange of information. Midwives would travel with the patient and handover their care to the receiving hospital. We observed this to have successfully taken place.
- There had been two multidisciplinary learning days with another one booked. These were opportunities for staff from various specialities to share practice. The obstetrics and gynaecology doctors, nurses, midwives, anaesthetists, emergency department doctors and nurses were all able to attend.
- The safeguarding lead midwife worked closely with the paediatric safeguarding lead nurse.
- The MAMA service had links with other health professionals to provide varied and flexible support for patients including children's centres, women's refuge centres and the early help centre.
- Patients who were accommodated on the gynaecology ward but had been admitted under the care of another speciality (outliers) were seen at least daily by doctors from the relevant speciality.

## Seven-day services

- A business case had been presented to open the gynaecology day surgery unit seven days per week if the operating theatres could accommodate this.
- The emergency gynaecology clinic was open 9am to 5pm Monday to Friday as were the gynaecology outpatient department treatment rooms.
- Sonography was available in the antenatal clinic between 8.50am hours and 5pm hours Monday to Friday.
- The antenatal unit was open Monday to Saturday. On Sundays patients would be directed to the triage midwife on the delivery suite.
- The termination of pregnancy clinic was open five days per week Monday to Friday.

## Access to information

# Maternity and gynaecology

- There was no formal system for the exchange of information, including required visits, for the community midwifery teams. The community midwives did not have a base in the community. They worked from home and there was no expectation that they were present in the hospital community office. They exchanged information via email or phone. This meant there was no centralised system for the allocation of work.
- Community midwives, who were home based, could access the computerised record system from the hospital or a GP surgery, including blood test results. However they had no means to review or complete computerised records in the patient's home.
- Records and booking histories were hand written by the community midwives and then the midwife attended the hospital to put this information onto the computer system. The medical history needed to be printed for the hand held notes; however midwives had to attend the hospital to complete this and there could be a delay of two to three days.
- When a patient contacted the maternity triage midwife a record of the call and advice given was kept. This was available for other midwives to understand any pattern through numerous calls.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- An audit of compliance with the Tameside and Glossop Integrated Care NHS Foundation Trust Policy for Consent to Examination and Treatment had been undertaken in the Maternity Department in June 2016. The outcome of this audit was not available at this inspection.
- We reviewed two consent forms for gynaecology patients and both had been completed fully. These were done at the preoperative assessment clinic and reviewed on the day of surgery.
- An audit into consent for surgical procedures had taken place across the trust. Learnings were shared with maternity and gynaecology services by way of meetings, notices and discussions at ward level.
- We saw clear documentation by midwives that they had obtained patients' consent to carry out examinations, including both internal and external.

- Consent for caesarean sections were clearly documented including the potential complications. The mode of anaesthesia was also documented and consent signed by the patient.
- Consent for termination of pregnancy met national guidelines. There were sufficient doctors willing to sign as the second signatory that patients' treatment was not delayed waiting for this to occur.
- Staff in the maternity and gynaecology services understood their responsibilities in terms of the Mental Capacity Act and the Deprivation of Liberty Safeguards. They were able to discuss examples of where patients may need an assessment of their mental capacity.

## Are maternity and gynaecology services caring?

Good



We have rated maternity and gynaecology services as good in caring because:

- We observed calm, patient, friendly and professional interactions between staff and patients in all areas of women's health.
- The results of the trust's inpatient survey on the gynaecology ward showed that all respondents agreed they were treated with compassion.
- The trust scored better than the England average in six of seven questions about treatment during labour and birth.
- Patients' independence was respected and supported during care and treatment.
- Patients and their supporters were involved in their own decisions and choices and kept informed throughout their care.
- There was a good understanding about the need to provide individualised care for patients in all areas.
- Emotional support was offered and guidance of how to access other services was provided when required.

## Compassionate care

- We observed calm, patient, friendly and professional interactions between staff, patients and relatives in the maternity unit and the gynaecology ward.



# Maternity and gynaecology

- We heard midwives and nurses speak about patients in a respectful manner. They showed consideration for patients with social issues and discussed in a professional manner what help could be accessed.
- The privacy and dignity of patients was protected in all women's health services. This included providing care behind closed doors and screens and staff being aware of the privacy required when discussing patients care and treatment amongst themselves.
- Midwives understood the value to the patient of consistency of a familiar midwife to offer care and support. An example of one midwife completing five antenatal visits, being present during labour and continuing postnatal care in the community was given.
- Staff on the gynaecology ward treated older patients with respect and showed an understanding of their additional needs due to physical frailty.
- Staff in the termination of pregnancy clinic were very kind and supportive to patients who may have difficult decisions to make. Patients could stay in a single room in the unit following a medical termination until they felt able to leave.
- The trust's inpatient survey results for May 2016 on the gynaecology ward showed that of 33 respondents all strongly agreed or agreed that they were treated with compassion by hospital staff.
- On the central delivery suite of 31 responses to the friends and family survey in June 2016 83% were extremely likely to recommend the service. This was displayed at the entrance to the unit.
- The trust scored better than other trusts in six questions out of seven about how they were treated by the staff during labour and birth. This included being treated with respect and dignity. They scored the same as other trusts in the other areas.
- The trust had been in line with the England average for friends and family recommendation scores for all four sections.
- Partners were accommodated to stay with patients on the delivery suite and the maternity ward. Recliner chairs were provided for their comfort and those we spoke with said they had been made welcome.
- Where a caesarean section was recommended by an obstetrician we saw documentation of patients being given time to discuss this with their partners when appropriate.
- Partners were encouraged and supported to attend a caesarean section should they wish.
- Partners were part of the skin to skin experience following birth should they wish and were supported to do this.
- Information was provided to patients and partners to assist them to safely care for their new-born baby. This included pictorial information on all cots about safe skin to skin positioning.
- Patients were able to continue to manage their own care if they had been doing this successfully at home. An example was a patient on the delivery suite managing her own dosage calculations and administration of insulin within a risk assessed basis.
- Where a patient in the gynaecology ward had declined to leave their bed, potentially putting themselves at risk of harm, a thorough discussion about the risks and choices of the patient was documented.
- Patients who attended the termination of pregnancy clinic were given time in the appointments with the nurse and doctor to discuss any issues or concerns. They had the option to return at a later date should they wish to do so.
- Staff involved patients in the decision making about a termination of pregnancy. If they were concerned they did not have a full understanding they took extra steps to assist them such as involving an interpreter.
- Patients were provided with information leaflets regarding fetal movements and this information was in the hand held notes. This included actions to take should a patient be concerned.

## Understanding and involvement of patients and those close to them

- Parent education classes took place on Saturdays and Sundays which included birth preparation and a tour of the maternity unit. Patients told us this made it easier to attend.

## Emotional support

- Support following a bereavement in the maternity services was available through a bereavement support group and specialist midwife.

# Maternity and gynaecology

- The screening midwife provided counselling for parents of babies with fetal abnormalities. Plans of care were developed with the fetal medicine consultant and these would be provided to the delivery suite manager in anticipation of admission.
- Patients in the termination of pregnancy service were offered emotional support from staff in the clinic.
- All services had information they could provide to patients about external agencies where further emotional support and counselling could be offered.

## Are maternity and gynaecology services responsive?

Good



We rated maternity and gynaecology services as good in responsive because:

- Services were planned to meet the social needs of people living in the area.
- The termination of pregnancy service was run to ensure patients could have additional support following their procedure should they need it. There was flexibility within the service delivery and staff responded to each patient's individual needs.
- The triage area of the maternity unit ensured patients could obtain prompt telephone advice and be seen in a timely manner.
- Patients could stay on the maternity ward if they required additional support.
- Whilst there was a lack of specialist midwives those with a special interest had taken the lead to offer additional support to specific patients.
- An initiative to assist patients with impaired mental capacity meant these patients were offered additional support.
- The enhanced midwifery team provided consistent support and care for patients with social, emotional or mental health needs.
- A specialist programme for supporting and informing pregnant women with alcohol consumption problems had been developed.
- Systems were in place to learn from complaints.

However:

- Inpatient beds on the gynaecology ward were used for patients from other specialities. Whilst this led to cancelled procedures they were rebooked within the required timescale.

## Service planning and delivery to meet the needs of local people

- The termination of pregnancy service was set up to accommodate local people who were referred via their GP. This service was open five days per week and meant patients did not have to travel or have a long waiting time for their treatment.
- The termination of pregnancy clinic was located away from the rest of the maternity and women's health wards and departments. This meant patients did not come into contact with pregnant women.
- The number of under 18 conceptions was higher than the England average as was alcohol and drug misuse. The enhanced midwives team was developed to provide consistent and specific support for this group of patients.

## Access and flow

- In the period August 2015 to July 2016 there were 56 last minute hospital cancellations of gynaecology operations for non-clinical reasons. All of these were completed within 28 days of cancellation.
- There was a bed management meeting at 8am every morning and the availability of beds for surgical patients would be discussed. The matron for the gynaecology services attended and where possible cancellation of gynaecology operations to provide beds for other surgical patients would be avoided.
- The gynaecology inpatient beds were also used for general surgical female patients and medical patients. During our inspection we saw that of six patients one was for gynaecology procedures, three for general surgical procedures and two for medical care. This meant gynaecology beds may not be available for those patients when required.
- The number of patients waiting over 18 weeks from referral to treatment time in the gynaecology outpatient clinic had increased since November 2015. In July 2016 92.40% met the target. Staffing issues and increased demand had caused the performance to reduce. Action had been taken and the backlog of patients was cleared therefore there was an expectation this would improve.

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- There was a uro-gynaecology outpatient clinic on a Monday and procedures took place twice weekly.
- There was a triage area which provided telephone advice and support or advice to attend the unit. This had been temporarily moved to ward 27 with the day assessment unit due to the refurbishment of the ground floor clinic area. The arrangements made during this period meant patients would be seen and assessed immediately on arrival and then may be redirected to a waiting area if their condition allowed.
- Managers told us the average length of stay on the maternity ward was between one and nine days. This included patients who may be having transitional care and therefore the timescale appeared longer than would be expected. However this did not correspond with information on the maternity dashboard which showed the average length of stay was within the trust's target of two days between April 2015 and March 2016.
- Bed occupancy on the maternity unit had been above the England average for the last 18 months however the highest it has been was 73%.
- The maternity unit had been closed six times between October 2015 and March 2016. The longest period was 14 hours and 30 minutes. An escalation policy was in place which included following the North West Ambulance service procedure.
- Midwives trained to complete the examination of the new-born were on duty every shift and this was allocated on the staff rota. There was also a paediatrician allocated to carry out these examinations Monday to Friday. This meant discharges should not be delayed because patients were waiting for these checks.
- There were a maximum of three inductions of labour booked per day; however they could be delayed which increased the number required. We saw this occurred during our inspection which meant there were five inductions carried out on one day. We were told whenever possible inductions were not delayed, however if emergencies were required they were rescheduled as soon as possible.

## Meeting people's individual needs

- Patients with a learning disability who required gynaecology procedures were supported by a multi-disciplinary approach. They could be supported by their carer throughout the process, the learning disabilities nurse would be involved in the planning of

the procedures and a consultant with an interest in learning disabilities would take the lead clinical role. Where necessary specific equipment or accommodation would be planned in advance and provided.

- A maternity passport for patients with a learning disability was being developed by the safeguarding lead midwife. This would consist of a multidisciplinary approach to a thorough document for each patient which would include their communication and comprehension abilities.
- The enhanced midwifery team managed the care for vulnerable patients such as those with mental health problems or drug and alcohol issues. They provided a flexible service of home visits to meet the needs of the patient and liaised directly with professionals from other services.
- There was a lack of specialist midwives although midwives with an interest in a clinical condition provided assistance at specialist clinics. This included the diabetes and mental health clinics.
- There was no specialist bereavement midwife; however a midwife with a special interest took a lead and had attended training sessions, offering advice and support to other staff.
- A programme for supporting and informing pregnant women with alcohol consumption problems had been developed. MAMA (Maternal Alcohol Management Algorithm) was managed by the safeguarding lead midwife. This provided pathways into related services in the community including rehabilitation day services, community support and detoxification support.
- Staff knew how to obtain translation services and said they could do so quickly if required. Written information could be obtained in languages other than English.
- We observed staff using translation services in the termination of pregnancy service to ensure patients full comprehension of information provided and promote clear two way communication for difficult decision making.

## Learning from complaints and concerns

- Data from the trust showed 4% of complaints between 1 May 2016 and 30 April 2016 were about maternity services.
- Complaints and concerns raised by patients were discussed by midwifery staff at their ward or team meetings. The obstetrics and gynaecology medical staff

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discussed complaints at the obstetrics and gynaecology speciality meeting. This included actions planned or taken to resolve the issues and reduce the risk of further complaints.

- Learning from complaints was discussed at the handover and informally between staff.
- Managers told us they would speak to patients as soon as possible if they were aware they were not happy with any part of their care.
- One patient on the maternity ward told us when they had raised a concern it had been dealt with immediately.

## Are maternity and gynaecology services well-led?

Good



We have rated maternity and gynaecology services as good in well-led because:

- There was a clear vision and strategy for the service which incorporated regional and national developments.
- Staff were focused on the delivery of good care for local patients and were aware of future service developments.
- Governance processes in place included oversight at trust, divisional and local level with resulting plans and actions reviewed through a robust process.
- The risk management process meant there was local ownership for risks with overarching management at a divisional level.
- Staff were complimentary about the leadership of the service saying they had approachable, visible and knowledgeable managers.
- Processes were in place to support and encourage staff to progress into leadership positions if they wished.
- There was an open culture where staff felt enabled to discuss any concerns or ideas.
- Mechanisms were in place for staff and patient engagement and involvement in service development.
- There was a focus on improvement and sustainability both within the service and the wider health economy.

## Vision and strategy for this service

- There was a service development strategy for the division of surgery, women's and children's which contained the plans for change and improvement for 2016 to 2018. This included how the service would incorporate national and regional developments. Targets were set with development plans to achieve them.
- Maternity services had been reviewed in light of the Cumberledge report 'Better Birth: Improving outcomes of maternity services in England' which set out the vision for a five year forward view for maternity care. The implications for the long term provision of maternity care had been reviewed.
- The midwifery and clinical leaders had some concerns about the changes in the health economy which were taking place in the local geographical area. They saw their status as an integrated care organisation as a positive thing for them in terms of collaborative working with other agencies.
- Staff we spoke with were focused on providing a good service to local patients in order to remain the hospital of choice for pregnant women. They were aware of regional changes, but felt assured that there was a plan of service improvement which meant there were positive future plans for the service.
- The challenge for the service was the lack of ability to offer an alternative place of birth. There were plans to develop a midwifery led unit in the next year. Midwives and consultants were enthusiastic about the development of a midwifery led unit.

## Governance, risk management and quality measurement

- A patient and staff quality and safety forum (PASQAF) was in place to share learning between maternity, children's and surgical services. They met every two months and anyone could attend with all planned activity cancelled to encourage attendance.
- Information from these meetings showed progress on improvement projects, learning from investigations and results of audits with required actions were discussed.
- A safety and quality walk around of the maternity and gynaecology areas took place every month. This had been adopted from other services within the trust and adapted to meet the needs of women's services. A

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written report and action plan was produced following this activity. Actions included reporting equipment and estates issues and additional daily checks by ward staff being instigated. Good practice was also noted.

- The trust used an electronic data base system for risk registers overseen by the divisional and directorate managers. The risk register was a live document which was reviewed through the divisional governance processes.
- A review date was present for all risks; however there was no date that the risk had been entered onto the register. All risks had been reviewed in the past 12 months.
- Changes to the management of the risk register meant that ownership for the risks was with the manager of that specific area. The governance arrangements in place meant risks could not be on the risk register without them being shared and managed by a senior team.
- There was a monthly meeting of the management team for the surgery, women and children's division to review the risk register for that service. This included the divisional quality and safety team and the obstetrics and gynaecology governance team.
- A printed copy of the risk register was present in each area of the maternity services. This was to help staff understand risk management and increase ownership within each area.
- Any risk of 12 or above was monitored by the head of midwifery and the directorate manager and escalated via the service quality operation and governance group. At this group agreement was reached as to which risks needed to be escalated to the trust management. There were monthly meetings of the divisional quality and safety committee and all specialities could present and learn from each other.
- The trust's Risk Management Policy Strategy and Guidance Document described the trust's risk management process.
- Governance had been introduced to the mandatory study day. Presentations of discussions at the governance meetings were shared with staff. This was a new innovation having started the month previous to the inspection.
- There was an expectation by the clinical director that all consultants now attended the governance meetings.

## Leadership of service

- Staff in all areas of the maternity and gynaecology service were complimentary about the leadership in their area saying managers were visible and approachable.
- Nurses in the gynaecology and termination of pregnancy service told us they could discuss any aspect of their work with their immediate line managers or other managers should they need to. They told us leaders were responsive to their ideas or concerns.
- A strategy for the supervision of midwives for 2016/17 had been developed. This was designed to ensure that the supervisors of midwives critically examined and effectively managed the supervision of midwives.
- Part of the above strategy was the requirement for the supervisors of midwives to meet a minimum of 10 times per year to discuss and review clinical incidents, audits and their resulting actions. Also to agree on support mechanisms for midwives and facilitate changes in working practices.
- The managers of the maternity ward and the central delivery suite were experienced midwives who had brought new ideas to their role.
- Band 6 and 7 midwives had the opportunity to work in a leadership position to obtain the required skills and assist with career progression. This had encouraged staff to apply for leadership posts with 12 internal applicants for the last band 7 post advertised.
- The community midwifery service, including the systems of working, were under review. A new manager was in post and they were being supported to make the required changes to this service.

## Culture within the service

- Medical, nursing and midwifery staff described an open culture where they could discuss any issues, concerns or changes with colleagues or managers.
- Staff were listened to and encouraged to develop ideas and promote changes.
- Student midwives described an open culture with friendly and supportive staff of all grades.
- All staff told us they would raise any concerns immediately and could do this with managers of all grades.
- The emphasis by staff in all areas and of differing roles was on providing the best service they could for patients. This led to examples of cohesive working where ideas for change were encouraged.



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- Ancillary staff in both maternity and gynaecology services were included in ward meetings and contributed to improvements and sharing of ideas and learning. They felt valued by the midwives, nurses and managers of the service.

## Public engagement

- There was an active maternity services liaison committee which met bimonthly. At these meetings local and national initiatives were discussed and feedback was provided following any audits or quality reviews.
- This was described by those involved as a useful platform to discuss engagement with patients and local people to develop the services.
- A workshop had taken place in December 2015 to look at building better ways to engage with patients and users of services.
- There was a draft action plan for patient engagement and promotion for 2016/17. This included improvements in the marketing of the maternity service, increasing patient involvement and developing a new antenatal delivery model.
- Inpatient experience surveys were part of the routine monitoring of the trust. These consisted of 24 questions about the care they received including communication, privacy and dignity and timeliness.
- Patient experience is measured on the dashboard.

## Staff engagement







- Some meetings for staff to discuss the plans for the maternity services at the trust had been held. Staff were able to discuss their thoughts and concerns at these meetings.
- Staff had been involved in the plans for refurbishment of the antenatal clinic.
- There were plans for midwives to visit other midwifery led units to see how other trusts provided this care and bring ideas to the development of this service at the trust.

- Community midwives held departmental meetings. They had specialist speakers to include an educational element and midwives told us they attended in their own time as these meetings were useful.
- A weekly review meeting had been set up to assess the move of the gynaecology day surgery unit. Staff were able to give their opinions on the positives and any improvements identified at these meetings.
- Staff of all grades commented favourably on the inclusion of their ideas about service development and felt improvements were being made.

## Innovation, improvement and sustainability

- Representatives from the trust were involved in the regional maternity network including reviewing the benchmarking of patient outcome data.
- The sustainability of the unit with the changes in the health economy within Manchester was high on the agenda for the managers of the service. They had linked to a nearby trust and had initial meetings as to how they could work in partnership. These discussions were supported by the wider trust management.
- Senior managers told us there had been investment into maternity and gynaecology services structure by the trust. This included the introduction of a business manager for maternity and children's services who staff saw as a vital part of the team for development in the future.
- The business services manager had helped to obtain more equipment and changes in the service including obtaining grants for new cardiotography machines and environmental improvements.
- One of the main focuses for improvement and growth in the maternity services was the development of a midwifery led unit. There were several options for this being discussed; however at the time of the inspection there were no agreed plans.
- Medical, nursing and midwifery staff were enthusiastic about the service they provided and looked for ways within the scope of their own roles to make improvements. This included changes to the environment, learning from other services and support for changes within the service.

# Services for children and young people

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

## Information about the service

Tameside General Hospital provides a range of paediatric and neonatal services. Neonatal services are located on the first floor of the Charlesworth building which houses the ante-natal clinic, inpatient maternity services and delivery suite. Paediatric services are located on the first floor of the main hospital building in the children's unit.

The children's unit consists of 36 beds, which include a 17 bedded ward area incorporating two high dependency beds, an eight-bed paediatric day surgery area and an 11 bedded observation and assessment unit.

The neonatal unit has 13 cots and provides intensive care, high dependency care and special care for newborn babies.

A dedicated paediatric outpatient clinic is located on the floor below the children's unit and a paediatric accident and emergency area is situated next to the main accident and emergency department.

Children's community nursing services are also provided from Tameside General Hospital and this service is located adjacent to the paediatric outpatient department.

Hospital episode statistics (HES) data showed that there were 4,971 children and young people seen between March 2015 and February 2016; 94.5% of these were emergency admissions, 4.5% were day case admissions and 1% were elective admissions.

We conducted the announced inspection of Tameside General Hospital between the 8 and 11 of August 2016 and

performed an unannounced visit on the 18 August 2016. We inspected a range of paediatric services including the children's unit, the neonatal unit, surgical theatres and the paediatric outpatients department.

We spoke with 20 patients and/or carers, observed care and treatment, inspected 18 sets of patient records and ten prescription charts. We also spoke with 46 staff of different grades including nurses, doctors, consultants, ward managers, specialist nurses, play specialists and administrative staff. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.



# Services for children and young people

## Summary of findings

We rated services for children and young people as 'good' overall. This is because;

- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy.
- Documentation we reviewed across the neonatal and children's unit was generally completed to a good standard.
- Staff were aware of their roles and responsibilities with regard to safeguarding and knew how to raise matters of concern appropriately.
- Newborn Life Support training (NLS) had been completed by all staff in the neonatal unit.
- The service used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment and there were a number of evidence-based pathways in place.
- The number of neonatal staff Qualified in Speciality (QIS) was 97%.
- Good multidisciplinary (MDT) working was noted in areas we visited.
- Care was provided by committed, compassionate staff who were enthusiastic about their role.
- Parents felt confident about leaving their baby in the neonatal unit and said they felt their baby was in "safe hands" when they were not present.
- Results of the 2014 Children's Survey showed the trust performed better than the England average for 12 of the 25 questions.
- Open visiting was available to parents with infants on the neonatal and children's units and support was available with parking charges.
- Data from the trust indicated that between January 2016 and June 2016 93.9% to 97% of patients referred to paediatric services were seen within 18 weeks.
- Urgent clinic appointments were available within the paediatric outpatient department and ad-hoc appointments could be arranged for patients who required longer consultations.

- The Community Children's Nursing team (CCNT) provided intervention to help avoid hospital admission, reduce the time children spent in hospital and prevent readmissions.
- Quality and performance were monitored through paediatric and divisional dashboards. This covered data such as waiting times for appointments, did not attend (DNA) rates as well as incidents and complaints.
- Staff were passionate about their work and were committed to providing high quality care in sometimes difficult circumstances such as during busy periods or when caring for very sick children.
- Staff we spoke to in all areas we visited told us morale was good and colleagues were very supportive of each other.

However;

- Emergency equipment was located in a number of trolleys and boxes in the high dependency area of the children's unit and emergency intravenous fluids were secured in a padlocked cabinet alongside. This meant that in an emergency access to equipment and the fluids may be delayed.
- Safety testing for equipment was in place but we observed two ventilators that had not been serviced since 2013 and six breast pumps that had been due for servicing in 2014 on the neonatal unit. We reviewed this equipment on our unannounced visit and noted that servicing had taken place.
- Of the nine band 6 and 7 paediatric nurses on the children's unit all had completed Advanced Paediatric Life Support (APLS) with the exception of two new staff, however only three were up to date at the time of our inspection. Plans were in place for three staff to attend a course in September 2016 and three in January 2017. Risk was mitigated by the on-site presence of a paediatric registrar at all times. Advanced Paediatric Nurse Practitioners, working in the Paediatric Emergency Department had also completed APLS.
- In the 2014/15 Paediatric Diabetes Audit showed that fewer individuals had controlled diabetes than the England average.

# Services for children and young people

- Team meetings took place monthly in the children's ward but there were no regular staff meetings within the neonatal unit.

## Are services for children and young people safe?

Good



We rated services for children and young people as 'good' for safe. This is because;

- Emergency equipment was located in a number of trolleys and boxes in the high dependency area of the children's unit and emergency intravenous fluids were secured in a padlocked cabinet alongside. This meant that in an emergency access to equipment and the fluids may be delayed.
- Safety testing for equipment was in place however we observed two ventilators that had not been serviced since 2013 and six breast pumps that had been due for servicing in 2014 on the neonatal unit. We reviewed this equipment on our unannounced visit and noted that servicing had taken place.
- Medicines fridges were secured and the fridge temperatures recorded daily, however maximum and minimum temperatures were not recorded in accordance with national guidance.
- A paediatric early warning score (PEWS) audit completed on the children's unit in June 2016 showed that all patients had observations recorded however, PEWS was documented in 80.8% of patients.
- Of the nine band 6 and 7 paediatric nurses on the children's unit all had completed Advanced Paediatric Life Support (APLS) with the exception of two new staff, however only three were up to date at the time of our inspection. Plans were in place for three staff to attend a course in September 2016 and three in January 2017. Risk was mitigated by the on-site presence of a paediatric registrar at all times. Advanced paediatric nurse practitioners, working in the paediatric emergency department had also completed APLS.

However;

- Joint obstetric and neonatal mortality and morbidity meetings were held monthly. Mortality reviews for paediatric deaths were completed by the paediatric multi-disciplinary team and reported to the trust's mortality steering group.

# Services for children and young people

- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy.
- Documentation we reviewed across the neonatal and children's unit was generally completed to a good standard.
- Staff were aware of their roles and responsibilities with regard to safeguarding and knew how to raise matters of concern appropriately. Safeguarding training formed part of the trust's mandatory training programme.
- In services for children and young people, mandatory training compliance was 100%.
- Newborn Life Support training (NLS) had been completed by all staff in the neonatal unit.
- The trust had a major incident policy. Staff we spoke with were aware of the policy and where to locate it.

## Incidents

- Incidents were reported using an electronic reporting system. Staff described the type of incidents they would report and could demonstrate the process. Feedback was received both individually and via staff meetings and there was also a 'Closing the Loop' learning from experience newsletter circulated in the trust.
- There were no 'never events' and one serious incident reported by the trust within children's services between June 2015 and the time of our inspection. Never events are serious, wholly preventable, patient safety incidents that should not occur if the relevant preventative measures have been put in place. The serious incident related to a recent unexpected child death and a review was in progress at the time of our inspection.
- Between June 2015 and July 2016, 441 incidents were recorded by the children's unit, neonatal unit, community nursing team and paediatric outpatient's clinic. Of these, 440 were reported as low or no harm; 55 of the incidents classified as low or no harm related to medication and 64 related to specimens.
- We reviewed details relating to eight incidents involving medication, treatment and complaints. All of which documented the outcome of the incident and any subsequent action taken.
- Staff were aware of the duty of candour and could describe circumstances where it would be used. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Joint obstetric and neonatal mortality and morbidity meetings were held monthly. Mortality reviews for paediatric deaths were completed by the paediatric multi-disciplinary team and reported to the trust's mortality steering group. Key messages and learning points were then fed back to staff in team meetings.
- Debrief sessions involving paediatric staff took place following any child death to identify learning points.

## Cleanliness, infection control and hygiene

- The wards and clinical areas we visited were visibly clean and tidy. Staff were aware of, and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. Personal protective equipment such as aprons and gloves were readily available throughout the neonatal and children's units.
- Hand washing facilities, including hand gel were readily available in prominent positions in each clinical area.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Hand hygiene monitoring between February 2016 and June 2016 showed that 100% of the staff audited on the neonatal unit and the children's unit were compliant.
- Completed cleaning checklists were observed in the paediatric outpatients department and the neonatal unit. A schedule was in place for cleaning and changing curtains within clinical areas.
- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of these being used across all departments we visited.
- Parents in the neonatal unit told us they were provided with information regarding infection control and instructions on handwashing when they initially arrived on the unit.

## Environment and equipment

- The clinical areas we visited including the paediatric outpatient department had controlled access.
- Emergency resuscitation equipment was in place and records indicated this was consistently checked in most areas however some gaps were noted in the paediatric outpatient department.

# Services for children and young people

- Emergency equipment was not located in one place in the children's unit. Instead, it was spread out and located in a number of trolleys and boxes in the high dependency area. Emergency intravenous fluids were also secured in a padlocked cabinet. This meant that in an emergency, access to equipment and the fluids may be delayed. This was raised with the trust who advised that a resuscitation trolley had been ordered for the children's unit so that all emergency equipment and drugs would be kept together. The trolley was observed during our inspection and was due in service within a few weeks. Advice was provided by the medicines inspection team to address any risk until the trolley came into use.
- Safety testing was in place for most pieces of equipment. However, we observed two ventilators that had not been serviced since 2013 and six breast pumps that had been due for servicing in 2014 on the neonatal unit. This was brought to the attention of the trust who removed the equipment from use and arranged for servicing. We reviewed this equipment on our unannounced visit and noted that servicing had taken place. On our unannounced visit we also noted scales in the weighing room in paediatric outpatients had been due for electrical testing in November 2015.

## Medicines

- All medicines we looked at in the neonatal and children's unit and paediatric outpatients department were found to be in date and stored securely in a locked cupboard as appropriate, and in line with legislation.
- Controlled drugs were stored securely and accurate records maintained in accordance with trust policy.
- Medicines fridges were secured and the fridge temperatures recorded daily, however maximum and minimum temperatures were not recorded in accordance with national guidance. This was raised with the trust and an action plan was put in place. We observed during our unannounced inspection that recording of fridge temperature ranges had commenced and staff we spoke to were aware of a new standard operating procedure (SOP) that had been introduced.
- Paediatric medicines charts were yellow to distinguish them from adult medicine charts and of the ten prescription charts reviewed all were legible, signed and dated with the weight of the child recorded. Nine had allergies recorded and included the age of the child.

- Guidelines were available on the ward for the administration of medicines, and both the preparation and administration of injections were checked by two qualified nurses.
- Paediatric pharmacy support was available on the children's unit Monday to Friday.
- We observed medicine given to a patient by nursing staff on the children's unit, medication was given in accordance with the prescription and patient details were checked.
- We looked at one prescription chart and the patient had been prescribed antibiotics plus paracetamol and ibuprofen for pain. The antibiotic prescription had been reviewed by a pharmacist and a record made in the pharmaceutical care log on the prescription chart. The chart also stated that the child had an allergy to a particular brand of paracetamol but it was unclear as to the nature of the allergy. This was highlighted to the nurse who followed up straight away, and the child's parent clarified that the allergy was specific to this brand of paracetamol.
- A stock of take home medicines were stored on the ward to give to patients discharged outside of the pharmacy's opening hours. Processes were in place to ensure the safe issue of medicines at the point of a patient's discharge.
- In the paediatric outpatients department, doctors prescribed medicines for patients to take home on an internal out-patient prescription form or completed a form for the patient's parent to take to their GP.

## Records

- Documentation audits were completed monthly and results from July 2016 indicated the children's unit achieved an overall compliance of 95%.
- We reviewed 18 sets of records across the neonatal and children's unit which were generally completed to a good standard. All records were signed and dated, diagnosis and management plans were present within medical records and evidence of multi-disciplinary working and escalation was documented as required.
- All patients on the neonatal unit had documentation for infants requiring neonatal intensive care. Staff we spoke with told us these charts remained in use for all babies even when intervention reduced to high dependency or special care.

# Services for children and young people

- Pink communication sheets were observed in records in the neonatal unit. These were used to document conversations between parents and medical staff.
- Any child where there was social or child protection need had a specific information sharing form in their records to inform staff. We observed a form completed appropriately in a patient's records.
- Records of inpatients were stored in a notes trolley in a locked office with keypad entry in the neonatal unit.
- On the internal corridor within paediatric outpatients we observed a red bag on a trolley outside each consulting room. Managers told us this was to store records for the next patient due to be seen. Issues regarding record confidentiality and security were raised and managers told us that a member of staff was always in attendance in this area. This issue had also been discussed at the Records Management Group and meeting minutes from July 2016 confirmed this.
- Two safeguarding practitioners were based on the children's unit and provided additional support and advice to staff and safeguarding champions were identified across the trust.
- Safeguarding indicators were included on the documentation used in the paediatric accident and emergency (A&E) department and included information such as any delay in attendance, inconsistent history or if a safeguarding plan was in place.
- A DNA (Did Not Attend) process was in place in the paediatric outpatients department and we observed a flowchart detailing action to be taken, including if patients were subject to a Child Protection Plan.
- Serious case reviews (SCR) were discussed at the trust's internal safeguarding group and information and lessons learnt were feedback to staff via safeguarding champions. A serious case review takes place after a child dies or is seriously injured and abuse or neglect are thought to be involved.
- Tameside Safeguarding Children's Board produce "seven minute briefs" to highlight key learning points from a SCR. However, not all staff we spoke to were aware of these.
- Electronic referrals were made to paediatric health visitor liaison based in the community and details of primary care professionals were obtained as part of the admission process. This ensured communication with community health professionals who were involved with the child, enabled information regarding current safeguarding concerns to be shared and ensured continuity of care between hospital and community.
- Parents of children subject to a medical examination as part of a child protection investigation were sent information advising of the process and both parents and children were invited to provide feedback regarding their experience.

## Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to and staff knew how to access them.
- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Safeguarding training formed part of the trust's mandatory training programme.
- The trust's target for safeguarding training was 95%. Data provided by the trust showed that of 124 staff identified in paediatrics and the neonatal unit 123 were compliant with level 3 safeguarding training (99%) with one further member of staff due to attend in September 2016.
- The trust's safeguarding adults training target was 95% and data from the trust showed 100% of staff from paediatrics and the neonatal unit who required the training were compliant with safeguarding adults level 2.
- Multi-agency safeguarding training took place annually and multi-agency safeguarding supervision occurred three to four times per year.
- A named midwife for safeguarding children and a safeguarding lead doctor were identified within the trust. A named nurse was in post at the time of our inspection however, the matron for children's services was to take this as an additional role from September 2016 until a new named nurse was appointed.

## Mandatory training

- Staff received mandatory training in areas such as fire safety, infection control, information governance and resuscitation. Training was delivered online as well as face to face.
- The trust's target for mandatory training was 95% and data from the trust showed that 100% of staff in paediatrics and the neonatal unit were compliant with required training.
- Managers and staff we spoke to told us reminders were sent to staff when training was due.



# Services for children and young people

## Assessing and responding to patient risk

- The trust used a Paediatric Early Warning Scores (PEWS) to monitor the condition of a child within the Accident and Emergency (A&E) department and the children's unit. This included observation of the patient's vital signs, such as pulse and respiratory rate. If a child's condition deteriorated the score for the observations increased and gave an indication that intervention may be required.
- A paediatric early warning score (PEWS) audit was completed on the children's unit in June 2016 which showed that all patients in the sample had baseline observations recorded, 81% of patients had observations within 1 hour of arrival on the observation and assessment unit and PEWS was documented in 80.8% of patients. Recommendations for further action included improving awareness of PEWS guidance and actions among medical and nursing staff in staff meetings and ward rounds, clear documentation in medical and nursing notes when a patient was reviewed and regular PEWS audit every 4 months to assess compliance with the trust policy and improve practice.
- Of nine records reviewed in the children's unit, six had a documented PEWS score.
- There was no early warning score in use on the neonatal unit. Managers and staff told us that visual observations and assessment were performed and professional judgement was used to decide on escalation. Records we reviewed indicated concerns had been escalated as required.
- Of the nine band 6 and 7 paediatric nurses on the children's unit all had completed Advanced Paediatric Life Support (APLS) with the exception of two new staff, however only three were up to date at the time of our inspection. Plans were in place for three staff to attend a course in September 2016 and three in January 2017. Risk was mitigated by the on-site presence of a paediatric registrar at all times. Advanced paediatric nurse practitioners, working in the paediatric emergency department had also completed APLS.
- All staff at band 5 and above on the children's unit were trained in Paediatric Immediate Life Support (PILS) and all staff below band 5 were trained in Paediatric Basic Life Support (PBLs).
- Paediatric acute illness management training had been completed by 60% of band 5 and 6 nurses.

- Newborn Life Support training (NLS) had been completed by all staff in the neonatal unit.
- Monthly identification band (ID) audits were completed on the neonatal unit. Results from the audit in July 2016 showed all nine babies had an ID band in situ, however only five babies had both ID bands in situ as per policy. Recommendations for further action included all staff in the neonatal unit being made aware of the importance of compliance with the current policy, each baby being checked at the beginning of each shift for placement of two ID bands and monthly audit. A further audit in August 2016 showed an improvement in compliance.
- Transfers of infants between hospitals were completed by the Cheshire and Merseyside Neonatal Network Transport service. The transfer of high dependency children was completed by the North West and North Wales Paediatric Transport Service.
- Children and young people who required child and adolescent mental health services (CAMHS) were admitted to the ward from the A&E department and were seen by the CAMHS team the next working day.

## Nursing staffing

- The expected and actual staffing levels were displayed within the neonatal and children's unit.
- Staffing within the children's unit was determined through the use of a dependency tool, which assessed the dependency level of patients against the number of qualified nurses on a shift. This was reviewed three times a day and ensured sufficient numbers of trained nursing and support staff with an appropriate skill mix to give patients the right level of care. Staff and managers told us that if acuity rose, medical and nursing staff worked collaboratively to facilitate discharge of patients or close beds to ensure staffing ratios remained appropriate. We observed a rise in the dependency score during our inspection and staff described the action taken.
- Staff and beds were also flexed between the ward and observation and assessment unit to allow for redeployment of staff according to patient need and we observed appropriate staffing at the time of our inspection.
- Between June 2015 and July 2016, four incidents were recorded relating to staffing on the children's unit.
- Monthly safer staffing reports were provided to the trust board and a review of nurse staffing in the children's unit

# Services for children and young people

was completed in July 2016. This concluded that an increase in the nurse establishment by 3.67 whole time equivalent (WTE) trained nurses would provide the unit with a core group of staff who could be deployed across the observation and assessment area, inpatient area and day case area. This would help to accommodate seasonal variation and fluctuating age and dependency levels of children and young people admitted to the ward.

- A band 6 nurse was always on duty in the observation and assessment area to provide advice and support to staff.
- A similar review of nurse staffing was conducted in the neonatal unit in June 2016, which found that between 1 August 15 and 30 April 16, 52.75% of shifts were filled to standards of staffing recommended by the British Association of Perinatal Medicine (BAPM) compared to a national average of 61.06%. As a consequence, plans had been put in place to address the staffing challenges identified including reviewing the band 7 structure and monitoring benchmarking data and trends in the Paediatric Governance Group.
- Neonatal unit nursing numbers we reviewed for the three months prior to our inspection indicated that BAPM standards had been achieved on 53% of shifts in May, 70% of shifts in June and 82% of shifts in July 2016.
- Managers told us that bank staff were used to cover for staff shortages in the neonatal unit and that shifts were mainly covered by existing staff members who were familiar with the unit.
- Between June 2015 and July 2016 three incidents were recorded relating to staffing on the neonatal unit.
- We observed a nursing handover that was completed using a tape recorder. Staff pre-recorded the nursing handover which was subsequently played to the staff at change over at the start of their shift. This provided information such as the name, age, diagnosis, observations, medications and treatment plan of patients on the ward. This approach meant that staff could not ask questions or seek clarification, however we observed staff obtaining additional information from colleagues after the handover following allocation of individual patients.

## Medical staffing

- There was sufficient medical staff to meet the needs of the children on the Paediatric unit.

- The percentage of consultants working in paediatrics within the trust was 32% which was lower than the England average of 39% however managers told us that an additional consultant post had been recruited to.
- The percentage of middle career doctors was 17% compared to an England average of 7%, the percentage of registrars was 42%, which was lower the England average of 47% and 10% of the medical staff were junior doctors which was higher than the England average of 7%.
- Consultant paediatric and neonatal cover was provided 24 hours per day.
- Paediatric consultants took part in a 'hot week' rota which also included management of any child protection work that may be required.
- We observed a clinical handover which was well structured and included the band 6 nurse from the observation and assessment unit.
- The trust also employed advanced paediatric nurse practitioners (APNP) who worked in paediatric accident and emergency (A&E) seven days per week 9am - 10pm.

## Major incident awareness and training

- The trust had a major incident policy. Staff we spoke with were aware of the policy and where to locate it.
- Managers told us a winter management plan included arranging nurse staffing to accommodate increased activity in the winter months. A business plan had also been submitted to increase the nursing establishment to help accommodate seasonal variation.

## Are services for children and young people effective?

Good



We rated services for children and young people as 'good' for effective. This is because;

- The service used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment and there were a number of evidence-based pathways in place.
- Policies and procedures were in place and staff we spoke with were aware of how to access them.



# Services for children and young people

- The children's unit used age dependant pain assessment tools and worked in partnership with parents to assess pain in patients with complex needs.
- All trained staff on the children's unit had completed competencies for medicines management and medical devices including those used in High Dependency Unit (HDU).
- The number of neonatal staff Qualified in Speciality (QIS) was 97%.
- Good multidisciplinary team (MDT) working was noted in areas we visited.
- Staff were aware of the principles when obtaining consent from a child.

However;

- The rate of multiple (two or more) emergency admissions within 12 months (March 2015 to February 2016) among children and young people aged 1-17 years with asthma was 25.4% compared to the England average of 16.5%.
- The 2014/15 Paediatric Diabetes Audit showed that fewer individuals had controlled diabetes than the England average.

## Evidence-based care and treatment

- The service used national guidelines such as those from National Institute for Health and Care Excellence (NICE) to determine care and treatment provided. For example, the service used guidance for the recognition and treatment of neonatal jaundice and guidelines for high flow nasal cannula for respiratory support in neonates.
- There were a number of evidence-based pathways in place such as an asthma referral & management pathway for children over two years of age and a pathway for self-harm/overdose relating to children and young people.
- Policies and procedures were in place and could be accessed via the trust's intranet. Staff we spoke with were aware of how to access them.
- The neonatal unit belonged to the Greater Manchester Neonatal Educators Group.
- The neonatal unit had achieved UNICEF Level 3 Baby Friendly accreditation.

## Pain relief

- The children's unit used age dependant pain assessment tools. For younger children, a faces pain rating scale was used and for older, children pain was assessed using a number scoring system.
- Staff we spoke with told us they worked in partnership with parents to assess pain in patients with complex needs and support was available from anaesthetists for acute pain control.
- Recording of pain score compliance was reviewed monthly for inpatients on the children's unit and compliance between February 2016 and May 2016 ranged from 63% to 80%.
- Visual observation and anticipatory prescribing of sucrose was used on the neonatal unit prior to procedures taking place.
- Analgesia and topical anaesthetics were available to children who required them in the ward and the outpatients department.
- Parents we spoke with told us their children had been given pain relief when they had needed it.

## Nutrition and hydration

- A range of menus were available on the children's unit. Patients told us they were happy with the food choices and that the "food was okay".
- Infants on the neonatal unit were weighed regularly and fluid balance was monitored.
- Specific neonatal dietetic support was available and infants were reviewed in the outpatients department following discharge as required.
- Designated breast milk fridges were kept on the neonatal unit and children's unit and mothers were encouraged to express breastmilk.
- Paediatric dietetic support was available on the children's unit Monday to Friday.

## Patient outcomes

- The trust provided data for the National Neonatal Audit Project (NNAP). The latest published report was in 2015 using data from 2014 which showed the trust were not meeting the NNAP standard of 100%. The results indicated there was a documented consultation with 88% of parents and/or carers within 24 hours of admission; this ensures that parents have a timely explanation of their baby's condition and treatment. In addition, 25% of eligible babies were discharged feeding only their mother's milk and 33% taking some mothers milk. Results also showed 100% of children were

# Services for children and young people

screened on time for Retinopathy of Prematurity (ROP). ROP is an eye condition that can affect babies born weighing under 1501g or 32 weeks gestation. Action plans were developed to address areas for improvement.

- The rate of multiple (two or more) emergency admissions within 12 months (March 2015 to February 2016) among children and young people aged one to 17 years with asthma was 25.4% compared to the England average of 16.5%. This was discussed with medical and nursing staff during our inspection who suggested this may be due in part to the 72 hour open access offered on the observation and assessment unit following discharge as any further attendance within this timeframe is counted as a second admission. Further paediatric asthma data submitted by the trust for external audit indicated readmission rates within 3 months with a further episode of wheezing or asthma were lower than the England average however the results were based on a small sample of 11 records.
- The rate of multiple (two or more) emergency admissions within 12 months (March 2015 to February 2016) among children and young people aged 1-17 years with Epilepsy was 26.9%, which was better than the England average of 29.4%.
- The 2014/15 Paediatric Diabetes Audit showed that fewer individuals had controlled diabetes than the England average. A dedicated paediatric diabetes action plan was developed by the trust to address the results of this audit. Progress was discussed with medical staff and managers and reviewed in the Children's Diabetes Team Annual Report which covered the period 1 April 2014 – 31 March 2016. Actions taken included additional funding for individual glucose monitoring, identification of a second special interest consultant, and appointment of a second paediatric nurse specialist and a paediatric psychologist.
- Admission of term infants (not classed as premature) to the neonatal unit was reviewed monthly to identify any trends.

## Competent staff

- Staff identified their learning needs through the trust's appraisal process and the trust target was 95%. Trust data showed that between April 2015 and March 2016,

80% of Nursing and Midwifery Registered staff, 79% of Medical and Dental staff and 93% of Additional Clinical Services staff within Children's Services had received an appraisal.

- Induction processes were in place for new staff and students and preceptorship was in place for newly qualified staff.
- Junior medical staff reported they had received a good programme of induction and nursing students reported feeling supported and well supervised.
- All trained staff on the children's unit had completed competencies for medicines management and medical devices including those used in HDU.
- Staff on the children's unit reported receiving additional training in the care of child and young people with mental health problems.
- The number of neonatal staff Qualified in Speciality (QIS) was 97%. This is a standard level of knowledge and skills for nurses within neonatal care.

## Multidisciplinary working

- Good multidisciplinary team (MDT) working was noted in areas we visited. Clinical staff told us there were good working relationships between medical and nursing staff.
- Records we reviewed indicated MDT working was appropriate and paediatric pharmacy support was available Monday to Friday.
- Children referred to child and adolescent mental health services (CAMHS) were usually seen the next day between Monday and Friday.
- Meetings were held with social care and community professionals as required. For example, in cases involving safeguarding or for patients who required discharge planning such as infants receiving oxygen.
- Paediatric Health Visitor liaison informed community professionals when a baby was admitted to the neonatal unit and when children and young people had attended the accident and emergency department.
- GPs were advised by telephone when a baby was discharged from the neonatal unit. Summary letters were also sent to a patient's GP and health visitor following discharge from children's services.
- Specialist nurses were in post to support young people transitioning to adult services and joint clinics took place for young people with diabetes from 16 years of age.

# Services for children and young people

- A working group was in place to develop pathways for the transition of patients from paediatric to adult services with the aim of transitioning to primary care rather than all patients transferring automatically to secondary care.
- A teenage alcohol worker was in post and a referral pathway in place in the accident and emergency department to ensure timely referrals to the alcohol service.

## Seven-day services

- Seven-day services were provided on the children's unit including the assessment unit as well as the neonatal unit, x-ray and A&E. The community children's nursing team was also available seven days a week, however appointments in the paediatric outpatient department were only scheduled Monday to Friday.
- Child and adolescent mental health services (CAMHS) were available Monday to Friday. Children referred to CAMHS were usually seen the next day if admitted Sunday to Thursday.
- Play specialists worked Monday to Friday but no cover was provided during the weekend.
- Consultant on-call cover was provided out of hours.

## Access to information

- Policies and procedures were kept on the trust's intranet and staff were familiar with how to access them.
- Parent Health Child Health Records (PHCR) were completed by staff in the children's unit if patients were admitted for weight loss or at the parent's request.
- GP discharge letters were sent following discharge from the children's unit to ensure continuity of care in the community and a copy provided to parents.
- Discharge summaries were provided to GPs when babies were discharged from the neonatal unit.
- Figures from the trust showed the number of inpatient discharge summaries sent within 48 hours ranged from 83.5% in April 2016 to 74.7% in July 2016. The number of outpatient clinical letters sent within five days ranged from 80% in April 2016 to 37% in July 2016. Managers told us additional administration resources had been provided to support this function.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Play specialists frequently supported children and young people for procedures such as blood tests and radiological investigations. This ensured that information was provided at an appropriate level and that patients understood what was happening.
- Staff could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents.
- We observed the procedure of obtaining written consent for a child going to theatre and accompanied them to the anaesthetic room where we observed this reviewed again by the doctor, parent and child.
- Staff described how support would be obtained from specialist colleagues and the safeguarding team when dealing with parents who may lack capacity to consent to treatment for their children.

## Are services for children and young people caring?

Good



We rated services for children and young people as 'good' for caring. This is because;

- Care was provided by committed, compassionate staff that were enthusiastic about their role.
- Results of the 2014 Children's Survey showed the trust performed better than the England average for 12 of the 25 questions related to caring including parents feeling that their child was well looked after by the hospital staff and that they had confidence and trust in the members of staff treating their child. Responses to the remaining questions were the same as for other trusts.
- Parents said they felt confident about leaving their baby on the neonatal unit and their baby was in "safe hands" when they were not present.
- Parents stated information given to them was consistent and staff took time to "explain everything".
- Leaflets were available for parents on the children's unit covering a variety of topics.
- Parents were provided with the contact number for the ward on discharge to allow them to telephone for advice if they had any problems and in some cases were given open access to the observation and assessment unit for 72 hours.

# Services for children and young people

## Compassionate care

- Care was provided by committed, compassionate staff who were enthusiastic about their role.
- Results of the 2014 Children's Survey showed the trust performed better than the England average for 12 of the 25 questions related to caring including parents feeling that their child was well looked after by the hospital staff and that they had confidence and trust in the members of staff treating their child.
- Parents told us that "staff were amazing" and "brilliant" and they "couldn't fault them". They also said they felt "the baby is in safe hands" when they were not present.
- The NHS Friends and Family Test for the children's unit conducted between March 2016 and May 2016 showed the percentage of patients that would recommend the unit to friends and family ranged from 86% to 99% with a response rate ranging from 4.9% in March to 14.4% in May.
- Friends and Family data was unavailable for the neonatal unit as responses had only been collected since June 2016.

## Understanding and involvement of patients and those close to them

- We observed staff treating children, young people and their relatives with kindness and respect, both in person and on the telephone.
- Most parents told us they were kept fully informed by doctors and nurses, that staff took time to "explain everything" and that information given was consistent.
- Leaflets were available for parents on the children's unit covering a variety of topics including neonatal jaundice, lumbar puncture and head injury advice for under five year olds.
- Patients discharged from the neonatal unit were given a pack containing leaflets from a national charity that provides support for premature babies and their families. This included information regarding local support groups
- Parents encouraged to stay with their child on the children's unit and fold out beds were available at each bedside however newly delivered mothers were provided with a regular bed.

## Emotional support

- Parents felt confident about leaving their baby in the neonatal unit and stated they could always telephone to ask about the baby overnight.
- We spoke with parents of a child with complex needs who told us that staff were good at communicating and respected parents decisions.
- Play specialists accompanied children and parents to theatre.
- Parents were provided with the contact number for the ward on discharge to allow them to telephone for advice if they had any problems and in some cases were given open access to the observation and assessment unit for 72 hours.
- The Harebell Suite was available within the maternity unit to enable bereaved parents to spend time with their infant after they had passed away.
- Bereavement support and counselling for parents and siblings was accessed through a local charity.

## Are services for children and young people responsive?

Good



We rated services for children and young people as 'good' for responsive. This is because;

- The environment on the children's unit and in the paediatric outpatient department was bright and colourful.
- Every bed in the children's unit had an overhead television and a range of DVDs were available. Wi-fi was available in the paediatric outpatient department.
- The 2014 CQC Children's Survey showed the trust performed better than other trusts for facilities for parents and carers staying overnight.
- Open visiting was available to parents with infants on the neonatal and children's units and support was available with parking charges.
- Data from the trust indicated that between January 2016 and June 2016 93.9% to 97% of patients referred to paediatric services were seen within 18 weeks.
- Urgent clinic appointments were available within the paediatric outpatient department and ad-hoc appointments could be arranged for patients who required longer consultations.

# Services for children and young people

- The Community Children's Nursing team (CCNT) provided intervention to help avoid hospital admission, reduce the time children spent in hospital and prevent readmissions.
- Children were supported by play specialists to complete Friends and Family feedback on a computer tablet on the children's unit.

However,

- A pre-operative assessment was completed by play specialists in the paediatric outpatient department to familiarise children with equipment and procedures before admission but staff told us that not all children being admitted for surgery received this service prior to the day of admission.
- Services for children and young people had a number of patients who failed to attend for their appointments and the DNA (did not attend) rate ranged from 14.6% in April 2016 to 16.1% in July 2016, however actions were being taken to address this.

## Service planning and delivery to meet the needs of local people

- The environment on the children's unit and in the paediatric outpatient department was bright and colourfully decorated.
- The paediatric outpatient department was bright and airy and a metalwork sculpture of giraffes was positioned above the entrance.
- A mural was in place on the staircase approaching the neonatal unit containing quotes from parents whose children had been cared for on the unit.
- The ceiling of the main hospital corridor leading from the ward to theatres had jungle animals and play specialists told us that counting animals was used as a distraction for patients on the way to theatre.
- Play specialists were available 7.30am - 6.00pm Monday to Friday in the children's unit and attended theatre with patients.
- A play room and an adolescent recreation room were available in the children's unit so that children and young people had activities appropriate to their age.
- A sensory room situated in the children's unit was able to accommodate a bed if required and contained some portable equipment to enable children in cubicles to benefit from the experience.

- Every bed in the children's unit had an overhead television and a range of DVDs were available. Wi-fi was available in the paediatric outpatient department.
- Children were seen in the adult x-ray departments. One area was used for GP referrals and orthopaedics and had a separate waiting area with toys, seating and a television. The lower ground floor area was mainly for inpatients and facilities for children were observed but limited. However, staff told us that play specialist support was used in this area and the imaging of children was prioritised.
- Children attending for day case surgery could be accompanied by their parents into the anaesthetic room and there was a separate paediatric section in the recovery area.
- Parents were encouraged to stay with their child on the ward. A sitting area was available with a refrigerator and tea and coffee making facilities away from the patients' bedside but within the unit. Parents were able to make hot drinks that could be taken on to the ward in thermos flasks.
- The 2014 CQC Children's Survey showed the trust performed better than other trusts for facilities for parents and carers staying overnight.
- A vending machine was in place in the paediatric accident and emergency department (A&E) and refreshments could be obtained for patients if required.
- Breakfast and drinks were provided for breastfeeding mothers on both the neonatal and children's unit.
- The environment in the neonatal unit was welcoming and a mural on the stairs at the entrance contained comments received by staff from parents whose children had been patients.
- There were two rooms with en-suite facilities that could be used by parents on the neonatal unit who wished to stay overnight. The rooms could also be used by parents to gain confidence caring for their baby prior to discharge.
- Open visiting was available to parents with infants on the neonatal and children's units and support was available with parking charges.
- Play specialists displayed patient information in the paediatric outpatient waiting area that included subjects such as religious festivals, health promotion information and patient feedback.

## Meeting people's individual needs



# Services for children and young people

- The children's unit presented as a calm environment during our inspection and call bells were observed to be answered in a timely fashion.
- Interpreting services could be arranged to support families whose first language was not English and staff confirmed they knew how to access them but we did not see this in use during our inspection.
- A pre-operative assessment was completed by play specialists in the paediatric outpatient department to familiarise children with equipment and procedures before admission. Practical information regarding fasting instructions and what to bring in to the ward was also included. However, staff told us that not all children being admitted for surgery received this service prior to the day of admission.
- Children who were inpatients on the ward for extended periods had a play programme put in place. This was drawn up with parents and contained a timetable of activities to ensure developmental progress was supported during admission. We observed a completed play programme within the nursing records for a child whose admission had been estimated at four to six weeks.
- Paediatric outpatient appointments were arranged so that blood tests and consultations were performed on the same day to prevent patients attending on more than one occasion.
- Specialist nurses were in post to support young people transitioning to adult services and a working group was in place to develop pathways for the transition of patients from paediatric to adult services within primary care if appropriate.
- Children who were approaching the end of life had an advanced care plan written however we did not see any children requiring this during our inspection.
- Children admitted requiring Child and Adolescent Mental Health Services (CAMHS) were supported by ward staff who had received some in house training from CAMHS and a Young Persons Mental Health Nurse secondment post was being recruited to at the time of our inspection.
- The observation and assessment unit was open 24 hours a day and admission was either via the A&E department, primary care, for example GP or health visitor, or the community children's nursing team. Children who required further care were admitted as an inpatient on to the children's ward.
- Between May 2015 and May 2016, 4,682 children were treated in the observation and assessment unit. Of those 3,680 were discharged directly from the unit with the remaining 1,002 children transferred to the inpatient ward.
- Babies admitted to the neonatal unit that required intensive care for longer than 48 hours were transferred to a specialist unit.
- Data from the trust indicated that between January 2016 and June 2016 93.9% to 97% of patients referred to paediatric services were seen within 18 weeks.
- Data from the trust showed bed occupancy rates between August 2015 and July 2016 were 50.3% for the children's observation and assessment unit, 60.4% for the children's unit and 69.7% for the neonatal unit.
- Average admissions per bed day for the children's observation and assessment unit August 2015 to July 2016 was 1.8.
- Children referred to child and adolescent mental health services (CAMHS) were usually seen the next day if admitted Sunday to Thursday.
- Urgent clinic appointments were available within the paediatric outpatient department and ad hoc appointments could be arranged for patients who required longer consultations.
- Services for children and young people had a number of patients who failed to attend for their appointments and the 'did not attend' (DNA) rate ranged from 14.6% in April 2016 to 16.1% in July 2016. Managers told us the trust were planning to introduce text reminders to all patients prior to their outpatient appointment.
- The community children's nursing team (CCNT) provided intervention to help avoid hospital admission, to reduce the time children spent in hospital and prevent readmissions.
- The CCNT accepted referrals from the observation and assessment unit and inpatient ward as well as GP's and advanced nurse practitioners in the A&E department. The service was available 8am - 8pm seven days a week.

## Access and flow

- An advanced nurse practitioner was in post in the paediatric A&E department to support either transfer of patients to the children's unit, discharge or referral to the community children's nursing team as appropriate.



# Services for children and young people

and allowed children requiring treatment such as intravenous antibiotics or suffering with infections or respiratory problems where appropriate, to be cared for at home.

- The children's community nursing team provided clinics five days a week to follow up patients after discharge.

## Learning from complaints and concerns

- Information leaflets were available within the areas we visited advising patients about the Patient Advice and Liaison Service (PALS) if they wished to make a complaint.
- Staff were aware of the complaints process. Staff told us they would try and resolve issues immediately and if this was unsuccessful would direct the patient and family to the Matron and PALS.
- Learning from complaints was shared with staff during team meetings and via the 'Closing the Loop' learning from experience newsletter circulated in the trust.
- The trust did not use a child friendly complaints form. However, children were supported by play specialists to complete Friends and Family feedback on a computer tablet on the children's unit.
- The Performance Report for the Division of Surgery and Women and Children in June 2016 showed that between July 2015 and June 2016 four complaints were received relating to the paediatric outpatients department, four relating to the children's unit and two to the neonatal unit.
- Of these complaints all four in the outpatient department and two on the children's unit related to clinical treatment and one each from the children's unit and the neonatal unit related to the values and behaviours of staff. Between July 2015 and June 2016 the percentage of complaints responded to in the agreed time scale by the Division of Surgery and Women & Children ranged from 85.7% to 100%.

## Are services for children and young people well-led?

Good



We rated services for children and young people as 'good' for well-led. This is because;

- Staff we spoke to were aware of the trust's vision to become an integrated care organisation.
- Quality and performance were monitored through paediatric and divisional dashboards. This covered data such as waiting times for appointments, did not attend (DNA) rates as well as incidents and complaints.
- Corporate and divisional risk registers were in place, managers knew the risks and mitigating actions within their departments.
- Staff told us managers were visible and approachable.
- Staff were passionate about their work and were committed to providing high quality care in sometimes difficult circumstances, such as during busy periods or when caring for very sick children.
- Staff we spoke to in all areas told us morale was good and colleagues were very supportive of each other.
- Results of the 2015 NHS Staff Survey showed the trust scored better than the national average for acute trusts for staff satisfaction with the quality of work and patient care they were able to deliver and support from immediate managers.
- The children's unit had won the Nursing Times Student Placement of the Year award for 2016.

However;

- Team meetings took place monthly in the children's ward but there were no regular staff meetings within the neonatal unit.

## Leadership of service

- At the time of our inspection services for children and young people were led by a matron supported by a band 7 manager within the children's unit, three band 7 staff within the neonatal unit and two band 7 staff in the children's community nursing team (CCNT).
- Staff told us managers were visible and approachable.
- Doctors told us that senior medical staff were supportive and educational supervision was good.
- Monthly team meetings took place on the children's unit to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust.
- Staff we spoke with told us that members of the trust board were visible and completed 'walk arounds'.

## Vision and strategy for this service

# Services for children and young people

- The children and young people's service was working towards providing care up to 18 years of age and this had been introduced for surgical patients at the time of our inspection.
- Staff we spoke to were aware of the trust's vision to become an integrated care organisation.
- Managers described work being undertaken with colleagues in primary care on an outreach model of service delivery to provide appointments for patients closer to home. The model also aimed to facilitate transition of patients to community services where possible rather than automatically transitioning into adult services.

## Governance, risk management and quality measurement

- Quality and performance were monitored through paediatric and divisional dashboards. This covered data such as waiting times for appointments, did not attend (DNA) rates as well as incidents and complaints.
- Monthly divisional quality and safety meetings took place and were attended by senior staff including governance leads, consultants and matrons. Discussions took place regarding relevant governance issues including the divisional risk register, performance and clinical effectiveness.
- Paediatric speciality meetings took place monthly to discuss issues such as staffing, safeguarding and community paediatrics.
- Corporate and divisional risk registers were in place, managers knew the risks and mitigating actions within their departments.
- There were four risks rated at 12 for the children's and young people's service. One included the clinical risk to babies due to the temperature dropping in the breastfeeding room on the neonatal unit and nurses giving what could be considered as conflicting advice to parents about wrapping babies. A second identified risks to neonates where portable ventilators are not maintained as per equipment schedule. Due to the condition and vulnerability of infants in the neonatal unit life-saving equipment must be accurate and fully functional.
- There was a named executive at board level who led on services for children and young people.

## Culture within the service

- There was an open and honest culture in the service. Staff we spoke to were candid about the challenges they faced within the service and were proud of what worked well.
- Staff were passionate about their work and were committed to providing high quality care in sometimes difficult circumstances such as during busy periods or when caring for very sick children.
- Staff we spoke to in all areas we visited told us morale was good and colleagues were very supportive of each other.

## Public engagement

- The views of patients were actively sought within the children's unit using the NHS Friends and Family Test however responses had only been collected since June 2016 on the neonatal unit.
- We observed 'You said we did' noticeboards on both the neonatal and children's units which provided examples of changes in practice following patient feedback. This included the purchase of breastfeeding chairs on the neonatal unit and supporting prompt assessment and early, safe, supported discharge on the observation and assessment unit.
- The Paediatric Diabetic team facilitated a local parent network and ran internal monthly forums where parents were invited to attend.

## Staff engagement

- Results of the 2015 NHS Staff Survey showed the trust scored better than the national average for acute trusts for staff satisfaction with the quality of work and patient care they were able to deliver and support from immediate managers.
- Physical and psychological support services were available to staff and staff we spoke with were aware of how to access them.
- Team meetings took place monthly in the children's ward however there were no regular staff meetings within the neonatal unit.





## Innovation, improvement and sustainability

- The children's and young people's service was working with primary care colleagues to develop an integrated care service that aimed to provide care for patients closer to home.

## Services for children and young people

- The children's unit had won the Nursing Times Student Placement of the Year award for 2016.
- The children's community nursing team provided care at home to prevent hospital admission and support early discharge. This allowed children to be treated in their own home or have a reduced stay so lessening the impact of illness on the child and family.
- A service improvement project was in progress in the paediatric outpatients department to ensure attendance data was captured appropriately.

# End of life care

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

## Information about the service

The trust's end of life care service is provided by a consultant led hospital specialist palliative care (HSPC) team. The team includes a consultant in palliative medicine, a part-time medical specialist consultant, three palliative clinical nurse specialists, and an end of life care facilitator. The trust does not have a dedicated specialist palliative care ward; patients are cared for within ward environments appropriate to their conditions and symptoms. Although the medical and nursing management of end of life care patients remains the responsibility of the ward teams, the HSPC team provide an advisory and supportive service to all clinical areas of the trust. The HSPC team works closely, and collaboratively, with the nearby hospice and local community palliative care teams.

Between April 2015 and March 2016, 928 patients died in the hospital; 604 of these patients were referred to the HSPC in the last weeks and days of their lives. 58% of the referrals were for patients whose subsequent deaths were related to cancer.

The service includes a bereavement team which supports families through the necessary processes following the death of a relative. The mortuary team takes care of deceased persons transferred from other parts of the trust; facilitates family viewings; works closely with local coroners in undertaking post mortems; and liaises with funeral directors until the deceased person is released.

We visited the trust as part of our announced inspection on the 8 to 11 August 2016 and our unannounced inspection

on the 18 August 2016. During this inspection we visited Wards 40 to 46, the heart care unit, surgical unit, and the Stamford Unit at Darnton House (a location managed by the trust). In addition we visited the chaplaincy, the multi faith rooms, bereavement office, and hospital mortuary.

We observed how care and treatment was provided, and spoke with 33 members of staff. These included the hospital specialist palliative care (HSPC) team consultants and facilitator; palliative clinical nurse specialists; complex discharge staff; ward managers, nurses, healthcare assistants and administrative staff; mortuary staff and bereavement centre staff, and porters. We observed an additional eight staff carrying out their day-to-day roles in the care of patients at the end of life, and we spoke with four patients and carers to collect their views about their care and treatment. We reviewed 25 patient records which included do not attempt cardiopulmonary resuscitation documents.

We received comments from people who contacted us to tell us about their experience, and we reviewed a range of performance, management and governance information about the trust.

# End of life care

## Summary of findings

We rated end of life care services as 'good' overall, because:

- Care and treatment was provided safely to patients at the end of life. Infection control and prevention was embedded in the service and the environment, from the wards to the bereavement centre and the mortuary, was appropriate for the services provided. Staff were trained appropriately, and used appropriate tools and observations to identify and respond to patients whose conditions were deteriorating. Anticipatory medication for end of life was prescribed in line with the trust's policies. There had been no serious incidents relating to end of life care.
- The palliative clinical nurse specialist team and complex discharge team provided a seven-day service, and staff from the mortuary team were on-call to attend out of hours. The palliative nurse specialists provided cover 9am-5pm on weekends and bank holidays. The end of life care provided was in line with evidence based professional guidelines, and work was ongoing to improve the services provided following the end of life care audit. The HSPC team, the end of life facilitator and the mortuary manager were integral in developing and delivering additional training to nursing and medical staff throughout the trust in end of life care and care after death. There was effective and collaborative multidisciplinary working, including with the local hospice.
- It was evident that all staff involved in end of life care were passionate about, and delivered, compassionate care and supported patients and their relatives emotional, and spiritual, needs. Patients and relatives spoke positively about the care and information that had been provided to them. The same level of caring, sensitivity and respect was evident in the care after death provided by the bereavement and mortuary teams.
- Arrangements were in place for the rapid or fast discharge of end of life patients to their preferred place of care, which included transfer to hospice

within two hours. The trust was able to carry out post mortem scans where requested, and authorised by the coroner, which responded to the needs of rapid faith based funerals.

- End of life care services were represented on the trust's board by a non-executive director. The end of life strategy fed into the division's wider strategy, including national and regional healthcare developments. There was a clear reporting structure in place, and the leaders were visible, approachable and supported staff. The service engaged the local public in the Dying Matters campaign and were working closely with local students to develop the memory tree and garden for the bereavement centre.

However,

- The service had more work to do to further encourage the use of individual plans of care, and to meet its internal key performance indicator. There was inconsistency in the quality and completion of do not attempt resuscitation (DNACPR) forms in some parts of the hospital, and some information within the wards' end of life link nurse files were out of date. Although there had been a small increase in the proportion of people dying in their preferred place of care, this remained lower (worse) than the regional or national average. The proportion of patients for whom rapid or fast discharge had been requested, that were discharged within the defined timescales, was low.

# End of life care

## Are end of life care services safe?

Good



We rated end of life service as 'good' for safe, because:

- Staff had a good knowledge of the incident reporting system, and there were appropriate processes within the service for reviewing, discussing, and sharing learning from incidents. There were no serious or never event incidents reported by the service, and there were very low numbers of other incidents relating to the service.
- Infection control and prevention was embedded within the service. The environment and equipment within the bereavement centre and the mortuary were appropriate for the services provided.
- Anticipatory end of life medication was prescribed in line with the trust's policies. New algorithm flowcharts had been developed and included in the trust's symptom control guidelines. Ward staff used appropriate tools to monitor and respond to deteriorating end of life care patients, and were aware of the referral criteria and contact details for the HSPC team.
- Staff were trained in safeguarding vulnerable adults and children. The HSPC, palliative clinical nurse specialist, bereavement and mortuary teams had fully completed all mandatory training. Staff were aware of their responsibilities during major incidents.
- Medical and nursing staffing levels were appropriate for the service. Action was being taken to seek authorisation for an additional palliative clinical nurse specialist to relieve pressures at weekends and during leave.

### Incidents

- There were no serious incidents or never events relating to end of life care services reported by the trust between 1 June 2015 and 31 May 2016. A never event is a serious event that is a wholly preventable patient safety incident that should not occur if the preventative measures have been implemented.
- The trust had systems and processes in place for reporting incidents. Staff accessed, and were able to

demonstrate, the reporting system via the trust's intranet. Although the number of incidents relating to end of life care services was low, staff were able to describe the types of incidents that would be reported.

- The trust reported seven palliative care incidents through the national electronic reporting system between 1 June 2015 and 31 May 2016. One of these, which related to a potential missed opportunity to identify a tumour at an earlier stage, was classified as moderate harm. The remainder (which related to information, confidentiality, delayed referrals and discharge) were classified as no harm. Incidents were appropriately reviewed.
- Between 1 June 2015 and 31 May 2016, there were 14 incidents relating to end of life care services, all of which were classified as insignificant with no harm. Of these, ten incidents were reported by the bereavement office and related to failure to follow procedures, documentation and staffing issues. Three incidents were reported by the Macmillan nurses relating to documentation, consent and communication, and buildings and estates issues. The last incident related to an appointment issue with the palliative care team.
- Although there had been no incidents relating to the mortuary in 2015/16, staff were trained in and were familiar with the reporting system. The mortuary manager told us that, in previous years, staff reported a number of incidents relating to the poor preparation of deceased patients by ward staff; however, this had significantly improved as a result of training in care after death that had been delivered by the mortuary manager and the end of life care facilitator. The mortuary manager discussed learning from incidents with the team, which included identifying any training opportunities. Outcomes from incidents and learning was shared via the trust's intranet system.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There were no incidents relating to end of life services that triggered the duty of candour. However, senior staff we spoke with were aware of their responsibilities in relation to duty of candour, and in line with the trust's 'Being Open Policy' and 'Incident Reporting, and



# End of life care

Incident and Complaint Investigation Policy'. Staff told us that, even if the duty of candour had not been triggered, they would invite families to meet to discuss and resolve any complaints.

- Mortuary staff highlighted similar deceased persons' names on the information board and on the individual mortuary fridge door. This reduced the risk of staff misidentifying deceased persons. Deceased persons who had pacemakers or other implanted medical devices were identified on arrival at the mortuary and appropriate controls were in place for removing these.

## Cleanliness, infection control and hygiene

- All wards we visited had a sufficient supply of antibacterial gel, and hand-washing facilities.
- We observed ward staff following good practice in infection control and hygiene in line with the trust's policy. Staff washed their hands appropriately, and followed the bare below the elbow protocol. Staff were confident to challenge others in relation to compliance with this. Personal protective equipment (PPE), such as aprons and gloves were readily available in all areas we visited and were used by staff.
- The mortuary had specialist PPE for staff, including wellington boots, personal protective visors, and each staff member had their own respirators (breathing apparatus used to prevent the contraction of infection). Mortuary fridges were disinfected after use.
- We reviewed the cleaning rotas and logs for all areas of the mortuary. All areas we visited within the mortuary were visibly clean, with sufficient hand washing facilities and disinfectant gel available
- Deceased persons who had an infection were classed as high risk. They were placed within a body bag before being transported to the mortuary. Procedures were in place within the mortuary for handling high risk deceased persons. Only the senior qualified mortuary technicians worked with these persons, and full infection control procedures and protective equipment were used, including respirators where necessary. However, the other technicians were due to commence additional level 4 diploma education in October 2016, and it was envisaged that, once qualified, they would be able to assist post mortems of high risk persons.
- Strong extraction fans were available to reduce the risk from airborne pathogens and to enable staff to evacuate the area. Eye baths and first aid kits were available.

- The mortuary had procedures in place for unexpected findings during post mortem, such as a patient with unknown infection or implants. This included obtaining advice from appropriate specialists. The mortuary manager told us of an example where a deceased person was found to have radioactive seed implants; advice was obtained from specialists at The Christie hospital.
- Portering staff, who discreetly transferred deceased persons from the wards to the mortuary, had undertaken infection prevention training. Portering staff were able to describe the additional infection control precautions used when the deceased person had an infection. We observed porters cleaning the transfer trolley, mattress and covers following the transfer of a patient. Although not all portering staff were involved in such transfers, 72% of all portering staff had undergone infection prevention training since their employment transferred to the trust in July 2016.

## Medicines

- The trust had guidance in place for the prescription of anticipatory medication, and the use of syringe drivers. This included standard forms for the prescription of controlled medications and for the administration of the medication by district nurses in the community. Although the use of two forms increased the risk of errors being made (compared to one combined form) we saw no evidence to indicate such errors had been made.
- The guidance focused on the needs of each individual patient. It included algorithm flowcharts for the introduction to patients and their carers of the use of the individual plan of care; the management of pain; the management of symptoms of terminal restlessness and agitation; breathlessness and respiratory secretions; and, nausea and vomiting. This was in line with the recommendations in the National Institute for Health and Care Excellence (NICE) guideline (NG31) Care of dying adults in the last days of life.
- Pharmacy staff carried out daily reviews, and reconciliation, of medications for newly admitted patients. Anticipatory medications prescribed for end of life patients were checked for appropriateness by the pharmacists. Pharmacists audited the stocks of controlled drugs held on the wards every three months, and also removed expired or returned medication for destruction.

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- Medication prescription charts for inpatients were paper based, but discharge medication prescriptions were completed online. Although this increased the risk of transcribing errors from paper to electronic format, we found no evidence of such errors during the inspection.
- Each ward held its own McKinley syringe driver, which meant a driver was easily accessible when needed. Syringe drivers were transferred with patients on discharge, and arrangements were in place for their return to the trust from the community. Ward managers held responsibility for the driver and the link nurses held a log of their location in line with the trust's management of medical equipment/medical devices policy. This meant syringe drivers could be tracked if a patient was moved or discharged. Additional syringe drivers were available from the trust's stores, or borrowed from neighbouring wards, if needed.
- Medical equipment and devices used on the wards for end of life patients, such as syringe drivers, was tested, maintained, and repaired by the trust's medical equipment service department (MESD). A maintenance database and schedule was in place, which meant there was an inventory of all medical equipment and maintenance or repair work carried out.
- The syringe drivers we checked on the wards were appropriately tested. Unless found to be faulty, they were returned to the medical equipment service department for calibration annually. However, we found one syringe driver on Ward 44 that had passed its equipment service date in April 2016 without being serviced. We raised this with the ward sister who took appropriate action with the MESD department
- Nursing staff on the wards wore red tabards marked 'Drug Round: Do not disturb'. This meant that patients received their medication appropriately and reduced the risk of mistakes being made.

## Records

- Patient records were held on wards in lockable trollies, which were stored in a room behind the nurses' stations when not in use. Response to a referral, and assessment of a patient, by the HSPC was recorded in the patient notes by use of a green sticker. This meant that advice from the team was easily identifiable within the records.
- The mortuary used a three point patient identification system; confirmation of the deceased person's name on

the board, on the fridge, and in the patient's records. This ensured the risk of misidentifying a patient was reduced. We reviewed the records held by the mortuary, which were complete and appropriately signed.

- Last office checklists completed by ward staff were transferred to the mortuary with the deceased person. In line with the trust's standard operating policy on the registration and release of bodies, details from the checklist were subsequently entered into a central log, which was updated by mortuary technicians after each relevant action was carried out.

## Safeguarding

- Safeguarding vulnerable adults and safeguarding children training was included in the trust's mandatory training programme.
- Against the trust's target of 95%, the trust reported full completion of safeguarding level two by all teams involved in end of life care, except the complex discharge transfer team which, at the time of the inspection, had a completion rate of 75% for safeguarding children training. The end of life care facilitator held safeguarding level three training.

## Mandatory training

- Staff received mandatory training in equality and diversity, fire awareness, health and safety, infection prevention, information governance, safeguarding adults and children manual handling, and where appropriate to the role, resuscitation.
- The trust reported 100% compliance with mandatory training for the HSPC team, which included the palliative clinical nurse specialist team.
- The bereavement team were compliant apart from one team member who had yet to complete the manual handling training.
- The complex transfer team were compliant with mandatory training in all but the safeguarding children module (75% completed) and the equality and diversity module (50% completed).
- The employment of the portering team transferred to the trust in July 2016. As part of the transfer, all portering staff were provided with induction training and a programme was put in place for managing the mandatory training requirements. At the time of the inspection 72% of portering staff had undergone

# End of life care

infection prevention and control training. This meant that portering staff involved in the transfer of deceased persons understood the need to implement infection control measures.

## Assessing and responding to patient risk

- Nursing staff undertook patient intentional rounding checks (checks on patients at set times to assess and manage their fundamental care needs). These included checks on the effectiveness of pain control, pressure area integrity, personal care, and mouth hygiene. This meant that changes to patient's conditions and needs could be more easily identified.
- Ward staff used the national early warning score (NEWS) tool to identify patients whose condition was deteriorating. Staff told us they also took into account change in the patient's behaviour or communication, which were often picked up and reported by healthcare assistant staff.
- Of those ward staff we asked, all were aware they could obtain advice and information from the HSPC team during working hours, and from the advice line out of hours.

## Nursing staffing

- As patients approaching the end of life were cared for across the trust, responsibility for their care lay with all staff and not just with the HSPC team. The HSPC team included an end of life care facilitator.
- Two band 7 and one band 6 palliative clinical nurse specialists (2.4 whole time equivalent), managed by the lead cancer specialist nurse, supported the HSPC team. The palliative clinical nurse specialists provided seven-day cover from 9am to 5pm; however, in light of an increased number of referrals, the team had developed and were awaiting authorisation of a business plan for an additional staff member. Administrative functions were covered by team members as there was no administrative support available.
- Four complex discharge nurses facilitated rapid discharges for patients, and were supported by the trust's transfer team. The transfer team worked closely with the local authority, nursing and care homes, and primary care support to enable patients to be discharged to their preferred place of death.
- Each ward had one end of life care link nurse.

- The mortuary was staffed by two qualified technicians and two partially qualified technicians. In addition the mortuary had three volunteers; it was envisaged that the volunteers would be trained to certificate level.

## Medical staffing

- General medical care and treatment for patients coming to the end of their lives was provided by medical staff within the ward environment. However, the HSPC consultants in palliative medicine were available to provide specialist advice, support, and care.
- The HSPC team was clinically lead by a consultant in palliative medicine. A medical specialist consultant provided part-time support.
- The consultant was available Tuesday to Friday 8.30am to 5pm. On very rare occasions, the team contacted the consultant for advice on weekends. An out of hours advice line was available.

## Major incident awareness and training

- A major incident policy was in place. HSPC, bereavement centre, and mortuary staff were aware of the policy and where it could be located.
- Staff had received training and knew their responsibilities during incidents. For the HSPC team this included reviewing end of life patients to determine if they could be relocated to the local hospice, and for the nursing staff on the team to assist in the medical assessment unit.

## Are end of life care services effective?

Requires improvement



Although we saw good elements of effective care, we rated end of life care services as 'requires improvement' for effective, because:

- Although there had been a steady increase throughout the year from 50% to 58% usage of the individual plan of care with patients who had been recognised by the multidisciplinary team as being at the end of life, the trust did not achieve its target of 75% usage of the plan by clinicians. This meant that 42% of end of life care patients were not cared for under the 'Principles of care and support of the dying person guidance' or under the 'Individual plan of care and support for the dying person in the last hours or days of life'.

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- There was inconsistency in the quality and completion of do not attempt cardiopulmonary forms (DNACPR) across some areas of the hospital we visited.

However,

- The palliative clinical nurse specialist team and the complex discharge team provided a seven-day service to support end of life care patients and ward staff. Although the bereavement team, and mortuary team did not provide a full seven-day service, the mortuary staff were available on call to attend the hospital for complex cases at weekends or out of hours. The palliative clinical nurse specialists provided a seven day service from 8.30am - 5pm
- Care and treatment was provided by the HSPC teams, and ward staff, in line with evidence-based professional guidance and the trust's policies. Staff were competent and appropriately trained to carry out their roles, and received appropriate supervision and appraisals. End of life care patients were, increasingly, cared for using an individual plan of care, which assessed and continually reviewed patients' individual needs and those of their families and carers.
- The service developed an action plan to address the areas of weakness identified in the 2015 End of Life Care Audit. A number of actions had already been completed, including additional training for staff and the development of symptom control algorithm guidelines for anticipatory medications.
- Processes were in place for assessing patient's pain relief, nutrition and hydration needs.
- There was effective multidisciplinary team working between the teams providing care for end of life patients within the trust and, externally, with the local hospice and the teams providing care in the community. The bereavement and mortuary teams worked effectively with the coroner's office, the chaplaincy services, and local funeral directors.
- The service consistently achieved 100% in two out of its three internal key performance indicators for appropriateness of patient transfer to the hospice, or for patients wishing to be discharged home within 24 hours.

## Evidence-based care and treatment

- The trust participated in the National Care of the Dying Audit of Hospitals (NCDAH).

The findings from the 2013/14 audit showed the trust achieved only two of the seven organisational key performance indicators. In the clinical key performance indicators the trust scored 70% and above in each indicator, which was better than the national average in every indicator.

- The trust participated in the 2015 End of Life Care Audit: Dying in Hospital, which replaced the NCDAH. The results published in March 2016 indicated the trust achieved six out of the eight organisational indicators. The trust had a lay member on the board with responsibility for end of life care; it sought the views of bereaved relatives and friends; in house training on communication skills for care in the last days and hours of life was in place for registered and non-registered nursing staff; face to face palliative care was available Monday to Friday between 9am and 5pm; and, an end of life care facilitator was in post. Training in communication around end of life care for medical and allied health professional staff were the two organisational indicators not achieved.
- Care and treatment provided by the HSPC team was evidence-based and in line with policies and guidance from a range of organisations including the National Institute for Health and Care Excellence (NICE). The trust used an 'Individual plan of care and support for the dying person in the last days and hours of life'. This was developed in 2014 by the Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks Palliative and End of Life Care Working Group. Introduction of the plan of care throughout the trust was completed by December 2015. Although use of the individual plan of care had increased during the year, the end of life care facilitator was working towards increasing the usage rates of the plan and actively challenged consultants who were not using the individual plan of care.
- The service does not currently follow the national gold standards framework for end of life care. This was because, until the recent appointment, there was no consultant in palliative medicine in post to lead the team. However, the service developed symptom control guidance for anticipatory medication, which included algorithm flowcharts for recognition that a patient may be dying.
- We saw evidence that analgesia and anticipatory medication was prescribed in line with NICE clinical

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guideline CG140 Palliative care for adults: strong opioids for pain relief. We also saw evidence that staff identified patients approaching their last days of life and took appropriate actions in line with NICE quality standard QS13 End of life care for adults, and the Leadership Alliance for the Care of Dying People's Priorities of care for the dying person.

- We observed ward staff providing care and treatment to patients in line with the evidence-based guidance. This was supported by documented evidence in the patient records we reviewed.

## Pain relief

- The trust's Individual plan of care and support included initial assessment of the patient's symptoms including pain and prompted medical staff to consider the strategic clinical network's pain and symptom control guidelines or referral to the HSPC team. The plan of care recommended ongoing review at least once daily, with patient assessment carried out and documented at least every four hours in a twenty-four hour period.
- The service developed and implemented a pain relief algorithm pathway within the end of life symptom control guidance for anticipatory medication.
- We observed staff responding to a patient's request for medication for relief of pain and breathlessness. Staff responded quickly, and took all the relevant steps to check the patient's prescription, identification, ensure double-checking and authorisation for dispensing the controlled medication before administering it.

## Nutrition and hydration

- Ward staff used the malnutrition universal screening tool (MUST) to identify patients at risk of malnutrition. Assessment of nutrition and hydration was an integral part of the individual plan of care for patients at the end of life. This aimed to support dying patients to eat and drink to their ability. It prompted staff to consider assessment by speech and language therapy teams if necessary, to record a patient's capacity and multidisciplinary best interests decisions on nutrition and hydration, to encourage relatives to assist if they wished, and to clearly record decisions and discussions relating to stopping or starting nutrition.
- The dietician visited wards daily to assess patients as appropriate.

- The head of hotel services (catering) told us that all food was freshly prepared on-site, and as such they were able to be more responsive to patients' needs. Catering staff were able to accommodate specific nutritional needs for end of life care patients.

## Patient outcomes

- The trust participated in the 2015 End of Life Care Audit - Dying in Hospital, which aimed to contribute to learning that could improve the quality of care and services for end of life care patients in England.
- The trust's data for the audit showed that it performed better than the English average in three of the five clinical key performance indicators (KPI). The third indicator (KPI3) measured evidence that patients were given the opportunity to have their concerns listened to (100% compared to the national average of 84%). The fourth indicator (KPI4) measured evidence that patients were asked about needs that were important to them (68% against an average of 56%); and KPI5 which measured evidence of a holistic assessment of the patient's needs in the last 24 hours of life through an individual care plan (92% against an average of 66%).
- The trust was worse than the English average in two of the clinical KPIs. The first indicator (KPI1) measured recognition that a patient would probably die in the coming hours or days (67% against an average of 83%). However, the trust's action plan noted that if sudden deaths were excluded it would have scored 100% against a national average of 93%. The second indicator (KPI2) measured evidence that recognised imminent death was discussed with those important to the patient (64% against an average of 79%).
- The trust achieved six of the eight organisational KPIs of the audit. These included having a trust board lay member with responsibility for end of life care (KPI6); obtained bereaved relative's views (KPI7); provision of training in specialist communication around end of life care for registered and non-registered nursing staff (KPI8b and KPI8c); the provision of face to face specialist palliative care at least between 9am and 5pm Monday to Friday (KPI9); and, the employment of an end of life facilitator (KPI10).
- The trust did not achieve KPI8a and KPI8d, which related to the provision of specialist communication training for medical staff and allied health professionals respectively.



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- However, the trust developed an action plan to address the areas highlighted by the audit. This included the delivery of additional training to general medical and nursing staff on communication, the use of the individual plan of care, symptom recognition, and the development of new algorithms for anticipatory medicines prescribing. The plan also promoted advance care planning, the recording of spiritual needs in the plan of care, communication with bereaved relatives including the use of the bereavement survey, and the promotion of available support from the local hospice.
- By August 2016, the audit results had been discussed in the mortality steering group meeting, the link nurse meeting, and the end of life steering group meeting. By the same time, the trust was in the process of implementing (or had already implemented) the majority of improvements identified in the action plan.
- The HSPC team received 592 referrals in the 12 months between July 2015 and June 2016, an average of 49 per month. The lowest number of referrals (24) was in October 2015, and the highest (73) was in March 2016. Approximately 55% of referrals were related to non-cancer end of life patients.
- The HSPC team measured performance against three key performance indicators. The first indicator measured the number of patients (identified by the hospital's multidisciplinary team as being at end of life), who were being cared for under the 'Principles of care and support of the dying person guidance' or under the 'Individual plan of care and support for the dying person in the last hours or days of life'. There was a steady increase throughout the year from 50% to 58% usage of the individual plan of care, which coincided with the introduction of the plan of care in all clinical areas of the hospital. However, this meant the trust did not achieve its target of 75% and that approximately 42% of all patients who had been recognised as being at end of life were not being treated under the principles or had not been placed on the individual plan of care.
- The HSPC achieved 100% compliance for the same period in both of its other two key performance indicators. These indicators were the appropriateness of transfer from the trust's medical assessment unit to the local hospice (target 70%), and the discharge of patients who wanted to go home within 24 hours of all their needs for discharge being met (target 70%).
- The end of life care facilitator delivered a range of educational programmes to staff, including last offices training for staff at all grades, and the Sage and Thyme effective communication skills course to staff involved in the care of patients in the last days of their life across the hospital. 51 staff were trained in the last twelve months. The palliative clinical nurse specialists also delivered training on issues around end of life care on the monthly Patient Focus Programme.
- The HSPC team provided training on palliative care emergencies and care in the last days of life to medical foundation year and GP trainees. This enabled the introduction and case discussion of individual plans of care, including how GPs can assess patients and work with the available services.
- The trust reported 100% compliance in completing appraisals for the HSPC, bereavement, and mortuary teams.
- Clinical supervision and peer support was provided to the palliative care clinical nurse specialists. An induction programme was in place for the end of life facilitator role, which included peer support and supervision.
- The mortuary manager and end of life care facilitator delivered training in care after death to 140 nurses since January 2015. The palliative clinical nurse specialist delivered a study day for nurses in the hospital, which included sessions with the nutrition nurse and complex discharge team.
- The mortuary was licenced by the Human Tissue Authority, and a designated individual was in place. The licencing certificate was displayed. Mortuary staff were UKAS clinical pathology accredited.

## Multidisciplinary working

- Multidisciplinary meetings were held weekly, chaired by the specialist in palliative medicine. A wide range of teams from the trust, the community, Macmillan, the hospice, and GP and nursing trainees were represented. This enabled effective communication about the care needs of new and existing palliative care and end of life patients, and shared information about recent deaths. This meant that transfer of care between the various teams was effectively managed.
- The end of life care facilitator worked closely with the community end of life facilitator with the aim of providing a seamless service between the community and the trust.

## Competent staff



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- Staff told us there was a good working relationship between the HSPC team, the bereavement centre staff, and mortuary staff. The end of life facilitator was based within the bereavement centre, which ensured effective and timely communication between all the teams.
- The HSPC team were involved in the end of life steering group for the roll out of the EPaCCS (electronic palliative care co-ordination system). The system was designed to enable the recording and sharing of people's end of life care preferences between local community GPs and the trust.

## Seven-day services

- The HSPC team were available Monday to Friday between 8.30am and 5pm. Although there was no consultant cover over the weekend telephone advice was provided to the team very occasionally.
- The palliative clinical nurse specialists provided a seven-day service between 9am and 5pm. One clinical nurse specialist provided weekend cover. A business case was being developed for one additional nurse specialist to provide additional cover for weekends and periods of absence.
- The complex care nursing team provided a seven-day service to facilitate rapid discharges for end of life care patients. The team were available Monday to Friday between 8.30am and 8pm, and on Saturday and Sunday between 8.30am and 4pm with cover from the transfer team until 8pm.
- An advice line operated by the Hospice was available to provide help and advice 24 hours a day, seven days a week, to patients, carers, and professionals.
- The bereavement centre and mortuary were open Monday to Friday between 8am and 4pm. Mortuary staff provided a 24 hour seven day a week on-call service for families to visit deceased relatives out of hours and for the urgent release of deceased persons for faith based funerals. The mortuary also provided an on-call service for the coroner in cases such as train deaths, road traffic accidents, and suicide.

## Access to information

- Staff had access to information they needed to provide effective care and treatment to palliative patients and those approaching the end of life. Patient records were

paper based. On all wards we visited paper records were securely stored in lockable trollies, and within lockable storerooms when not in use. Computers were available to access electronic test results.

- Staff were aware of the end of life team, and the specialist palliative care nurses, and held their contact details. Staff told us the teams were responsive to all requests for advice.
- The HSPC team used a green sticker system to record in the records that they had been to review the patient.
- Wards held a range of link nurse information files; these included a palliative care rapid discharge file. These held a range of information and relevant forms and checklists (and examples) for rapid discharges. This meant that ward staff had access to appropriate information and guidance when needed. However, we reviewed the link nurse files held on three wards and all contained out of date information.
- Patient paper records were transferred to the mortuary with the deceased person. This meant the records were available in the bereavement centre for review by doctors in completing the medical certificates of cause of death and cremation certificates.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust used its own DNACPR form. The purpose of a DNACPR decision is to provide immediate guidance to those present (mainly healthcare professionals) on the best action to take (or not to take) should the person suffer cardiac arrest or die suddenly. The DNACPR form captures relevant information about the reasons why the decision had been made, who had authorised the decision, and if the decision had been discussed with the patient or their family.
- We reviewed 25 sets of medical and nursing records which included do not attempt cardiopulmonary resuscitation (DNACPR) forms. Ten of these related to patients receiving care in the wards, seven for patients within the orthopaedics unit, four for patients in the heart care unit and two in the surgical unit. The quality of completion of the DNACPR forms for patients receiving care in the wards was good; and there was good evidence that patient risk assessments had been carried out, including nutrition and hydration, skin care, mouth care, and manual handling assessments.
- We found evidence of Mental Capacity Act (MCA) assessments being carried out as part of the fractured

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neck of femur patient pathway. We also saw documentation of a best interests meeting with a patient's relatives. However, in 10 out of 25 patient records we reviewed in the wards, where a DNACPR was in place, we were unable to find evidence that a MCA assessment had been carried out, or a documented reason for not undertaking one. Two records indicated that a mini mental state assessment had been undertaken rather than a MCA assessment; five did not provide evidence that a best interests decision had been recorded appropriately; six did not provide a summary or evidence of a discussion with the patients next of kin or family; and, eight did not record a ceiling of care.

- The trust's safeguarding and deprivation of liberty safeguarding (DoLS) leads were aware of issues relating to the low completion rates of MCA assessments across the trust. The leads were working to increase awareness, to support staff in carrying out assessments, and to check DoLS application forms. As a result there had been a gradual improvement; however, the leads recognised that more work needed to be done to embed MCA assessment and DoLS applications across the trust.
- We reviewed two DoLS applications on Ward 45, which cared for patients living with dementia. Both applications were complete, up to date, and signed. Staff on the ward had an appropriate level of understanding of MCA and DoLS assessments.
- The trust's DNACPR form, and decision, was only valid while the patient remained in hospital. Therefore, once a patient was discharged from hospital a new DNACPR assessment and decision needed to be made by the patient's GP. The trust recognised the development of a regional unified form (uDNACPR) which was being used within the community and by the North West Ambulance Service. The aim of the uDNACPR form was that it remained valid during a patient's transition of care between health providers. Although the trust was in the process of adopting the uDNACPR, this had been placed on hold pending the introduction of a new national DNACPR form which was expected to be published later in 2016. This meant that any delays in renewing DNACPR decisions in the community after a patient was discharged from hospital could lead to the patient being resuscitated inappropriately.

## Are end of life care services caring?

Good



We rated end of life care service as 'good' for caring, because:

- All members of the HSPC team, clinical nurse specialists, bereavement centre and mortuary staff demonstrated their passion for providing compassionate care that included patients and families as partners in their treatment. They supported patients', carers' and families' emotional needs through the last days of life, and following death.
- We observed ward nursing and medical staff responding sensitively, respectfully, and with kindness to questions and, sometimes, difficult and distressing requests from patients approaching the end of their lives. The same sensitivity, respect and dignity was maintained by portering staff and mortuary staff, in the transfer, storage and preparation of deceased persons.
- Patients and relatives we spoke to told us that staff had included them in discussions about their care and prognosis, and had answered any questions they had.
- The trust's chaplaincy teams provided spiritual support and emotional support could be accessed through the advice line.
- The trust's bereavement survey reflected significant improvements in the care provided to end of life patients, in discussion about their preferred place of care, and in the involvement of relatives in the care provided.

### Compassionate care

- End of life care patients were cared for throughout the hospital within wards that were relevant to their needs. The end of life care facilitator was working to introduce a butterfly symbol throughout the trust for use with end of life care patients. This was designed to be a discreet indicator for staff so that they could ensure additional sensitivity and compassion was shown to end of life care patients and their families. The system had been discussed at the end of life steering group, which included a patient representative who agreed with the introduction of the scheme.
- We observed several interactions with patients in the wards by medical consultants and junior doctors,

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nurses, health care assistants and physiotherapy staff. Although not all these interactions were with end of life care patients, staff consistently displayed a friendly, caring, supportive, and compassionate approach.

- Wards operated an open visiting policy for relatives of palliative patients and those approaching the end of life. Reduced rate car parking was available to families; however, this was offered on a weekly basis only. Where available, relatives of end of life care patients were able to have food from the ward trolley at meal times.
- Deceased persons' jewellery was presented to relatives within a small delicate presentation bag. The end of life facilitator was working towards introducing the ability for memento photographs of relatives holding the deceased person's hands. It was expected that this would be implemented once the trust's photographic policy had been updated.
- 14 thank you cards were displayed in the reception area of the bereavement centre. All the cards praised the exceptional care, kindness and compassion displayed by the bereavement and mortuary team.
- One card said: 'Thank you so much for looking after our precious [daughter] so beautifully. Your kindness and your care has helped us through a very difficult time. Thank you also for giving up your free time at weekends to allow us to spend precious time with our daughter. You will never know how grateful we are for these last few hours with her. We know [our daughter] was in good hands.'
- The trust's bereavement survey, which was carried out continuously and reported on monthly, asked families and carers 20 questions about their experiences. The questions focused on areas including communication by doctors and staff, discussion of the dying person's preferences and support for the family, involvement in the care of the dying person and their dignity; and the services of the bereavement team and mortuary.
- Between December 2015 and May 2016, the survey results reflected an improvement with the overall combined satisfaction result ranging between 75% and 86%. Although the survey covered both expected and unexpected deaths, the percentage of people who indicated they were able to discuss their relative's care with a doctor increased from 70% to 100% over the same period. The percentage of people indicating there

was a discussion of the location of care increased from 37% to 80%; and the percentage of people indicating they were involved in decisions about their relative's care increased from 65% to 80%.

## Understanding and involvement of patients and those close to them

- We observed medical and nursing staff responding to questions from patients and their carers. Staff clearly knew the patients, and explained their plans of care in an unhurried way using jargon-free language.
- We spoke with one patient and her son who told us that the care had been 'exceptional' and that nurses were always available and staff responded quickly in a sensitive way. The patient's son told us he felt he had been given sufficient information by staff and was able to ask questions at any time.
- We spoke with the son of another patient who told us that staff had previous and ongoing discussions with him about his father's approaching deterioration and death. The patient's son was aware of the clear ceiling of care that was in place, and had a clear understanding of the medications which had been prescribed and what they were for.
- Although there was no residential accommodation available for families, reclining chairs were available for relatives who wished to stay with the patient. Refreshment drinks and toast were available.
- Side rooms on wards were not solely for palliative patients or end of life patients; however, these were offered to patients and relatives if they were available.
- In the records we reviewed, we saw evidence of extensive, well-documented discussions with patients' families around the end of life care, DNACPR decisions, and care planning. This was in line with the recommendations on communication within the National Institute of Health and Care Excellence's guideline NG31 Care of dying adults in the last days of life, and the Five Priorities of Care of the Dying Person.
- Free car parking was available to families attending the bereavement centre to view their deceased relative, and to collect the medical certificate of cause of death.
- A range of information leaflets was available to families in the reception area of the bereavement centre. These included practical guides such as planning for future care; stopping mail to the deceased person's address; information about bereavement support; several

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leaflets for parents and employers relating to still births and neonatal deaths; leaflets for signing up for organ donation and to the Dying Matters campaign; and information about the services provided by the hospice.

- Families and carers were able to attach small notes to remember their relatives to a memory tree in the waiting area of the bereavement centre.
- The HSPC, bereavement and mortuary teams worked closely with local students from the local sixth form college in the Dying Matters project. The aim of the project was to raise awareness of issues surround the end of life. A memory garden was being designed as part of the project, and an area within the hospital had been identified for this although work had not yet started.

## Emotional support

- Although discussions with end of life care patients and their families were primarily the responsibility of ward medical and nursing staff, the palliative clinical nurse specialists and the HSPC team were available to support these discussions including the use of DNACPR.
- The palliative clinical nurse specialist team helped an end of life patient to create a memory box for their young children. The team expected to introduce this across the trust where appropriate.
- On the first day of our inspection, the palliative clinical nurse specialist team had facilitated a bedside visit from prison by the son of an end of life care patient. The team along with ward staff liaised with the prison medical team to arrange the visit within two to three hours. It was the patient's dying wish to see her son before she became unconscious, and this had been a main cause of anxiety for her in the last days of her life. The team's actions ensured the patient's wish was fulfilled before she was transferred to the hospice.
- An end of life board was displayed within the surgical unit, which provided information about the five priorities of care for the dying, organ donation, the Leadership Alliance for the Care of Dying People's approach of 'One chance to get it right'; and, contact details for services that were able to provide emotional support.
- The bereavement service was available Monday to Friday between 8am and 4pm. The bereavement services team produced a bereavement resource pack which was given to families collecting medical certificates of cause of death. The pack included several pieces of information to aid families' understanding of

the processes involved following the death of a relative. This included information on certifying death; making funeral arrangements and contact details of local funeral directors; details of religious and chaplaincy support; information on organ donation; informing government agencies of the death through the 'Tell Us Once' service; obtaining advice on probate issues; a directory of local and national support services; and emotional support. The resource pack was presented in a wallet which could also store the certificate.

- The chaplaincy team provided multi-faith support to patients and carers, worked collaboratively with the HSPC team, and attended the end of life care steering group. A chaplain was on site each day during normal office hours. A named chaplain was assigned to each ward, with rotation between wards every four to six months. The team were supported by 19 volunteers.
- The service was available on-call for urgent spiritual or religious needs 24 hours a day, seven days a week. The on-call rota was shared with the trust's switchboard, which meant that chaplains could respond within 30 minutes of a visit request.
- The team produced a range of supportive cards to leave with patients and their families, and were able to provide a range of faith texts on request.
- Mortuary staff were able to contact the chaplaincy to request a chaplain to attend to bless a deceased person if requested by the family.

## Are end of life care services responsive?

Good



We rated end of life care services as 'good' for responsive, because:

- The trust took part in the regional strategic care network for palliative and end of life care. The trust's end of life strategy and steering groups were working towards the network's goals.
- There was close collaborative working between the ward staff, HSPC team, the palliative clinical nurse specialists and the Hospice to ensure patients' needs were assessed and met.

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- Staff were responsive to the individual physical, spiritual and emotional needs of patients, and their relatives throughout the end of life care period and in care after death.
- Arrangements were in place with the pharmacy for medications, and the ambulance service for transfer, for patients being discharged under the rapid discharge policy.
- Facilities were in place for undertaking post mortem scans. This avoided invasive post mortems, and enabled earlier release of a deceased person for faith based funerals.
- Mortuary staff were available on-call out of hours for viewings and for releasing deceased persons to funeral directors.

However,

- Although there had been a small increase in the number of people dying in their preferred place of care, the proportion remained lower (worse) than the regional or national average.
- The percentage of patients discharged within the timescales defined by the trust's rapid and fast discharge process was low.
- Information held in the ward fast track palliative care discharge files included out of date and inaccurate information.

## Service planning and delivery to meet the needs of local people

- The trust submitted data to the regional Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks for Palliative and End of Life Care. The trust was also a member of the Manchester Cancer Palliative Care and End of Life Care Advisory Board, which aimed to develop a holistic model of palliative and end of life care and to ensure the best possible quality of life for palliative and end of life care patients with cancer.
- The trust's end of life strategy and steering groups drove developments and improvements in the end of life care services.
- End of life care patients were cared for and treated in all clinical areas of the trust, including the medical wards, heart care and surgical units. However, there was close

collaboration between the ward medical and nursing staff and the HSPC team and palliative clinical nurse specialists to ensure patients received appropriate and timely assessment of their needs.

- There were close links between the HSPC team, the hospice, and community palliative care teams. The weekly multidisciplinary meeting chaired by the consultant medical specialist ensured that all teams were updated on the care and treatment of most local end of life patients known to the hospital and the community.
- Between July 2015 and June 2016, records of the location of death for the trust showed 52% of people died in hospital, 21% at home, 15% in a care home, 11% at a hospice and 2% elsewhere. The figures show there was a positive trend downwards for the proportion of patients dying in hospital with a corresponding increase in the proportions dying in hospice or at their usual place of residence.
- The trust's figure for people who died in their preferred place of care (36%) was still lower (worse) than those in the Greater Manchester, Lancashire and South Cumbria region (44%), and worse than the England average of 46%. The trust's aspirational target for people dying in their preferred place was 47%.

## Meeting people's individual needs

- Interpretation services were available for people whose first language was not English. British sign language interpreters were also available. Information leaflets in other languages could be ordered by staff.
- Patients on the wards who were living with dementia were identified in records by the 'forget me not' symbol, and the Alzheimer's Society 'This is me' booklet was used to help support patients. Open visiting was available for relatives. In Ward 42 there were no dementia friendly rooms available; however, where possible, patients living with dementia were allocated to bays in front of the nursing station. Although staff told us there were no specialist trays used for meals, red-lidded jugs were used to identify patients who needed additional assistance or encouragement with their nutrition and hydration needs.
- Staff assessed end of life care patients living with physical or learning disabilities for any additional needs or equipment. This often included working with the patient's community key worker.



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- Ward staff were able to contact the HSPC team for advice and guidance on recognising pain and administering pain relief for end of life care patients living with dementia. Similarly staff were able to contact the trust's admiral nurse (a specialist dementia nurse) for advice and information if needed.
- In ward 40 a number of environmental changes had been made to improve the environment for patients living with dementia who were at the end of life. These had been suggested by the ward dementia link nurse and included the installation of ambient lighting in the ward and side rooms; the provision of quilts in appropriate designs for male and female patients, a Parker Knoll chair to enable relatives to stay by the bedside, and a tea set for relatives to use instead of plastic cups. Staff had received positive feedback from relatives on the changes.
- The individual plan of care included, where it was used, initial medical and nursing assessment of the dying person; initial communication with the person and their family or carers; discussion with the person or family about their preferences for care and any wishes relating to organ and tissue donation; multidisciplinary team assessment and nutrition and hydration assessment; maintenance of personal care; identification of the psychological, spiritual and religious needs of the dying person; and, the support needs for the family or carer. The plan included ongoing regular assessment of the dying person, noting that the individual plan of care should be discontinued and an appropriate care pathway commenced if they person was assessed to have improved and were no longer in the last days of life.
- We observed a nurse responding to an end of life care patient's request, which was made in front of her son, to 'let me die'. The nurse took time to discuss this with the patient, to acknowledge the patient's concerns, and to determine if more pain relief was needed. The nurse requested immediate review of the patient by medical staff who were undertaking a ward round at the time. The nurse also provided sensitive support to the patient's son.
- The trust developed a communication booklet for patients in the last days and hours of their lives to keep at their bedside. The booklet encouraged patients, their families and carers, to write down what staff needed to know or take into account in providing care, or any questions they wanted to ask about their care.
- Although the trust did not offer a counselling service, staff made patients and relatives aware of the advice line operated by clinical and clerical staff at the hospice. The line, which also provided advice and information to medical professionals, was available seven days a week with 24-hour cover Monday to Sunday. The advice line was able to provide information on issues such as pain relief, symptom control, psychological support, the use of syringe drivers, and the use of medications.
- The trust's bereavement guidelines included information on supporting the spiritual and physical care of patients and families of differing cultures and faiths, including actions to be taken during the last offices for deceased persons. This was supported by guidance on out of hours referral to the Her Majesty's Coroner for deceased persons whose faith needs required funerals to be undertaken within limited time periods. This information, including contact numbers for faith representatives, was available on the trust's intranet.
- Two multi-faith prayer rooms in the hospital were open 24 hours a day. These accommodated faith services including Holy Communion, daily and Friday prayers. A baby memorial service was held once a year in a local church. The team led Eid prayers for consultants working in the hospital. A carol service was held each December.
- The chief executive and the bereavement team worked closely with the chaplaincy and coroner's office to resolve faith community concerns about a delay in releasing a body. The bereavement team sent the relevant papers in person to the coroner's office to speed up the process, and the chief executive met with community leaders to explain and resolve concerns about the delays.
- The trust had a standard operating procedure for undertaking out of hours post mortem scanning to determine the cause of death. At the coroner's discretion and authorisation, this service was an alternative to a full post mortem being carried out, and was available to all families. Although there was a fee associated with this service, which was either met by the deceased person's family or community faith groups, this meant that funerals, including faith based funerals, were not delayed any longer than necessary and avoided the perceived desecration of the body of an invasive post mortem.



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- Bereavement centre staff told us doctors were responsive in attending to complete the relevant forms within a target of 48 hours after death for the medical certificate of the cause of death and 72 hours for cremation certificates. A rota was in place for second signatory consultants to visit the mortuary to examine the body and to complete the cremation certificate.
- Where the appropriate paperwork and authorisations were in place, mortuary staff were available on-call out of hours to release deceased persons for faith-based funerals. Although staff had not received any specific requests from families to wash their deceased relatives bodies, such requests could be accommodated by the mortuary staff.
- The trust carried out a monthly survey of funeral directors on the mortuary service. This asked six questions including the responsiveness and appropriateness of greetings by mortuary staff; the cleanliness and presentation of deceased person; and the respectfulness of the presentation of the deceased person. Between December 2015 and January 2016, the overall combined satisfaction result was 97%. The questions relating to the presentation of the deceased person, the respectfulness of presentation, and the cleanliness of the facilities, all achieved 100%. The question with the lowest result (84%) related to funeral director vehicle access to the mortuary during busy periods. Staff recognised this could be an issue during busy periods.

## Access and flow

- A standard operating policy was in place for accessing the HSPC team, which set out the referral criteria, contact details, and response expectations. Patients with cancer and non-malignant diagnoses were accepted if they had complex pain and symptom management needs, complex psychological distress needs, required assessment for hospice admission, had a palliative emergency at weekends, or required support for complex end of life care. Non-cancer patients were accepted for complex end of life care.
- The HSPC team received e-referrals and phone referrals. The e-referrals system was introduced to staff during their induction. The team accepted queries regarding end of life care plans through a dedicated email inbox. The team aimed to respond within one working day for

urgent referrals or four working days for non-urgent referrals. The palliative clinical nurse specialist team reported an approximate 73% achievement of responding to all referrals within 24 hours.

- Ward staff told us they had good access to the HSPC team, who usually responded on the same day. Additional information was available on the trust's intranet, and staff were aware they could obtain information from the advice line out of hours.
- The complex care nursing team facilitated rapid discharges for patients from hospital to their preferred place of care, which could be home, care home, or the local hospice. Staff attended ward board rounds each morning to ensure they are aware as early as possible of any patients due to be discharged. The team carried out complex nursing assessments to identify end of life care patients' health needs, to support fast track continuing healthcare funding for eligible patients, and to ensure that referrals were completed to the community specialist palliative care teams. They worked with local health and social care providers to procure individual care packages and equipment to meet patients' needs, and liaised between ward staff, consultants, GPs and patients families. However, staff told us they faced some challenges in the responsiveness of equipment supply for patients being discharged back to the Manchester local authority area where charges were raised for rapid delivery of equipment.
- The trust's standard operating procedure for the urgent integrated care team defined rapid discharges as occurring on the same day as the discharge was requested. Fast discharges were defined as discharges within 48 hours of the request. However, the trust only started to collate data against this criteria in April 2016. The limited amount of data available means that full analysis of the trust's performance is not possible. Between April and October 2016, rapid discharge was requested for twelve patients. Six (50%) of these patients were discharged on the same day; five (42%) were discharged within two days or less and one patient was discharged within seven days or less. This means the trust met its rapid discharge standard for same day discharge in 50% of cases. However, as there was no contextual data held for these discharges, it is not possible for us to say whether or not this was due to factors outside the trust's control.
- In the same time period, 151 patients were identified for fast discharge: 11 (7%) were discharged on the same

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day; 27 (18%) were discharged within two days or less; 52 (34%) were discharged in seven days or less; and, a further 22 (15%) were discharged within 14 days or less. The remainder were discharged after 15 days or more. This means the trust met the fast discharge standard of discharge within 48 hours for 25% of identified patients during this period. However, the absence of contextual data means it is not possible for us to say whether or not factors outside the trust's control contributed to this.

- Pharmacy staff prioritised prescriptions of anticipatory medications for patients being discharged home, and could provide a three to four day supply to ensure patients had medications to cover for weekends or bank holidays. This helped to prevent any unnecessary delay in discharging patients.
- In 2015/16, 185 end of life care patients were discharged from the hospital to the hospice. This represented a 110% increase since 2012/13 when 88 patients were transferred. Arrangements were in place for the rapid discharge of end of life care patients from the medical assessment unit to the hospice within 24 hours.
- An agreement was in place with the North West Ambulance Service for rapid transfer of end of life patients from the hospital to the hospice or home. This meant that, if a bed was available at the hospice, it was possible to transfer a patient within two hours.
- Fast track palliative discharge files were held on each ward to aid in the rapid discharge of end of life patients to their preferred place of death. The files held a range of information and forms, including although not limited to: a palliative care discharge checklist; district nurse anticipatory medication authorisation form and record charts; contact details, referral criteria, and referral forms for the HSPC team and other relevant teams and GPs for Tameside and Glossop; continuing healthcare assessment forms; flowcharts for rapid discharges including medical team responsibilities.
- However, a number of the documents held in the file were out of date or included incorrect information, which increased the risk of delays or errors being made by staff. For example, the information relating to the HSPC team was produced in September 2013 and had not been updated with details of the electronic referral facility. The flowcharts referred to the Marie Curie discharge team rather than the complex discharge team. The rapid discharge treatment plan referred to the 'integrated care pathway for end of life' (also known as the Liverpool Care Pathway). The district nurse

anticipatory medication authorisation form did not comply with individual plan of care recommendations, and the example provided in the folder showed that cyclizine, haloperidol and levomepromazine in the syringe driver section of the form were all signed which would be inappropriate. The syringe driver dose range for levomepromazine started at 12.5mg, rather than usual practice, which would indicate a starting dose of 5 or 6.25mg.

- The mortuary monitored delayed transfers of a deceased person from the ward or the emergency department to the mortuary by exception. The exceptions were reported using the incident reporting system where the arrival time at the mortuary was greater than the four-hour standard set by the trust in its bereavement guidelines. Between August 2015 to July 2016, out of a total of 1016 transfers, there were no exception reports generated which indicated that deceased persons were transferred to the mortuary in a timely manner.
- Mortuary staff used a spreadsheet to track the progress towards obtaining authority to release deceased persons to funeral directors. A policy was in place for obtaining out of hours coronial authorisation for release of a deceased person for a faith-based funeral. Staff used the spreadsheet to urge coroners to provide the relevant paperwork if it had not been received after three days.

## Learning from complaints and concerns

- End of life care complaints, and critical incidents, were discussed at the end of life steering group. Learning from these was shared by the end of life team, the bereavement team, and the mortuary team formally in team meetings. However, staff also told us that learning was also shared informally during the working day due to the close working nature of the teams.
- The HSPC team told us they had received three end of life care complaints, which all related to poor communication by ward staff. Learning from end of life complaints were feedback by the team to the relevant manager.
- One nursing staff member told us that her concerns and complaints about poor planning for a dying patient's discharge home was recognised by the end of life care steering group. The minutes of the steering group reflect

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this and noted that the staff member was invited to become an end of life care link nurse 'as it was so obvious that she was passionate about good end of life care for her patients'.

- The mortuary manager told us there had been no complaints received from relatives relating to the mortuary service. One complaint had been received from a funeral director, which related to availability of parking during busy periods.

## Are end of life care services well-led?

Good



We rated end of life care services as 'good' for well-led, because:

- End of life care services were represented at board level, with responsibility shared by a non-executive director, chief nurse and medical director.
- There was a clear management structure for the HSPC team, which was led by the consultant in palliative medicine who reported directly to the clinical director of medicine for clinical matters and to the directorate manager operationally. The end of life facilitator and palliative clinical nurse specialists reported to the lead cancer nurse. Close, collaborative and effective working was evident between the consultants, end of life facilitator, palliative clinical nurse specialists and the bereavement and mortuary teams.
- A clear divisional strategy in place which focused on delivering services against national and regional healthcare developments; implementation of seven day services; and integration with community services. The divisional strategy was supported by the end of life care services five year strategy to embed end of life care across the trust, community services, and care homes; the progression of advanced care planning; further development of support and advice networks; and the expansion of the services and skills for specialist nurses.
- There with clear reporting lines for staff. Staff told us that senior management were supportive, and approachable, and the chief executive was visible and had visited the departments.

- Students from the local sixth form college were actively engaged in the Dying Matters campaign and in developing the memory tree in the bereavement centre, and in ongoing plans for the memory garden.
- Continuous development and training was ongoing to improve the service and experiences for palliative and end of life patients. Close collaboration between the service and the local hospice on a palliative patient pain management programme was aiming to reduce A&E admissions.

## Leadership and culture within the service

- The end of life care service was part of the trust's division of medicine and clinical support services.
- There was a clear management structure in place from the HSPC team to senior management, and staff were aware of reporting lines. The consultant in palliative medicine reported directly to the clinical director of medicine for clinical matters and to the directorate manager operationally. The end of life facilitator and palliative clinical nurse specialists reported to the lead cancer nurse, while the bereavement and mortuary teams reported through the diagnostic directorate into the divisional director. However, there was close and collaborative working between all the teams.
- Bereavement centre staff told us there was a friendly and supportive culture within the team, with the mortuary staff, the HSPC team and also the hospital nurses and doctors. Bereavement centre staff delivered training to nurses to improve awareness of the work of the office. As a result, the quality of information provided by nursing staff to the bereavement office had improved.
- The mortuary technicians told us they felt supported by senior managers and the executive team, where were approachable. The chief executive was visible, had visited the department, and had sent a thank you letter to staff. The medical director regularly visited the department. There was a supportive atmosphere within the department, with good working relationships with the bereavement team. This helped families to relax at a time of distress. Staff supported each other with distressing situations, such as a child death.
- Palliative clinical nurse specialist staff told us there had been 'a lot of good changes since new management team were put in place'. The lead nurse and director of

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nursing were 'very approachable and receptive to being contacted' and staff considered that the executive team were visible and had developed a more positive atmosphere.

## Vision and strategy for this service

- The trust had a non-executive director on the board with responsibility for end of life care. This responsibility was shared on the board with the medical director and chief nurse.
- The trust had a set of five values: safety, care, respect, communication, and learning. Each value was supported by a set of behaviours, which were reflected in the trust's strategic corporate objectives. The objectives aimed to ensure harm free care; improvement of the quality of care and of the patient experience; development and integration of community services through working with communities and local partner organisations; and to deliver against local and national frameworks as part of Greater Manchester Health and Social Care Devolution.
- The trust's medical and clinical support services division included the end of life care services. The division had its own strategy in place, which was focused on delivering against a number of national and regional developments including the Healthier Together programme in the Greater Manchester region, implementation of seven day services, and the Tameside and Glossop locality plan of Care Together which aimed to increase life expectancy. The strategy included a key focus of integrating with community services, including palliative care, to provide robust and sustainable care pathways.
- An end of life care steering group supported the HSPC team. The group included representatives from the HSPC team, specialist palliative care nurses, chaplaincy, ward staff, the mortuary patient representatives, the community learning disability and dementia nurse, end of life facilitators from the trust and the community, and the lead cancer nurse. Standing items on the group's agenda included the use of DNACPR; the individual plan of care; training; equality and diversity; progress towards KPI targets; and the review of critical incidents.
- The HSPC team developed a five year strategy based on ten high level objectives to improve the end of life care service through changes in knowledge, skill and attitude. The objectives included: progression of advance care planning through use of a shared register

of patients thought to be at end of life; compassionate leadership; the embedding of end of life care within general practice; the introduction of a full time palliative care consultant at the trust supported by a dedicated senior manager; the introduction of a patient participation group, and a support network for carers; continuation of seven day telephone palliative care advice; the expansion of services and skills of specialist nurses in the community; and, the improvement of care homes' ability to care for patients approaching the end of life.

## Governance, risk management and quality measurement

- The trust's palliative and end of life strategy group met bimonthly. The group was chaired by the consultant in palliative medicine and had a wide range of representatives from the trust, the hospice, the local clinical commissioning group, GPs, specialist dementia and learning disabilities nurses, and trainee GPs and student nurses. The strategy group discussed updates from the strategic clinical network; progress towards the introduction of the electronic palliative care co-ordination system (EPaCCS); multi-professional education training (MPET) funding; innovations such as the palliative care mobile app; mortality reviews; and, ongoing issues.
- A separate end of life steering group met quarterly. The group included representatives from services across the trust that provided input to patient's end of life care and care after death, including a patient representative, chaplaincy representative, matrons, and the admiral nurse. The steering group reviewed progress in areas such as the use of the DNACPR, individual plan of care, training and progress towards the end of life KPIs, equality and diversity, critical incidents and complaints.
- The medical specialist consultant in palliative care and the end of life care facilitator attended the mortality steering group who validated the group's findings and provided updates on the use of the Individual plan of care in line with KPI results. These were also reviewed by relevant local GPs. The HSPC team reviewed all deaths within the previous 24 hours to determine if the patient had been cared for on an individual plan of care and if anticipatory medications had been prescribed

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appropriately. The review also looked at those who had been admitted at end of life from care homes to determine if advanced care planning could have prevented the admission.

- The trust's risk registers were held centrally on the trust's electronic safeguarding system, and were accessible by ward and departmental managers. There was no separate risk register for the HSPC team; risks for end of life would be included in the register for the specialities division of the medical directorate. However, the HSPC team told us they had not identified any significant risks at that time.
- However, the team recognised that palliative clinical nurse specialist staffing was an issue at times of leave or sickness. A business case was being put together for one additional nurse. Secondment opportunities were offered for long period of absence (such as maternity leave).
- Standard operating policies including referral criteria and guidelines were in place for the HSPC teams, the palliative clinical nurse specialists, bereavement team and the mortuary team. The service also had an out of hours coronial referral policy, organ donation policy, and was developing a verification of death policy for registered nurses policy.

## Public engagement

- The HSPC team as part of the National Council for Palliative Care's Dying Matters Coalition. The Coalition's Mission was to help people talk more openly about dying, death and bereavement, and to make plans for the end of life. As part of this the HSPC worked with students from the local sixth form college on the Dying Matters Campaign. This included the development of the memory tree which was displayed in the reception area of the bereavement centre, and designs for the future memory garden.
- In January 2016, the HSPC team co-organised and hosted the first Tameside and Glossop Palliative care conference alongside the community specialist palliative care team, the clinical commissioning group and the hospice. This raised awareness of the challenges in meeting palliative care needs and educated healthcare professionals across the primary and secondary care sectors.

- Three volunteers worked within the mortuary. The volunteers were supported to learn and understand the role of mortuary staff. Two of the existing mortuary staff worked as volunteers before being employed by the trust.

## Staff engagement

- The HSPC team engaged qualified nursing staff in a monthly patient focus programme, and delivered healthcare certificate training to band two staff members. The mortuary manager delivered care after death training.
- The end of life care facilitator was shortlisted for the trust's staff aware 'Everyone Matters' in recognition of making a difference towards improving patient care at the end of life.
- The bereavement, pathology and mortuary team were the 2015 winner of the trust's Everyone Matters Award.

## Innovation, improvement and sustainability

- The HSPC team, bereavement centre staff, and the mortuary staff were involved in the ongoing design and development of a memory garden, working with students at the local sixth form college. Benches and some planking had already been donated for the garden, and staff were intending to create a wall for plaques commemorating organ and tissue donations.
- The mortuary team were planning to repeat a Good Grief Day to raise awareness of the mortuary and issues relating to end of life. The aim was to include speakers from local crematoria, funeral director services, the coroner's service, and a counsellor from the hospice.
- A verification of death for registered nurses policy for expected deaths was in the process of being developed. This aimed at ensuring last offices were carried out for in a timely way and minimising delays in transfer of the deceased person to the hospital mortuary. The trust anticipated approximately 80 hospital nurses would be trained to undertake verification of death once the policy had been agreed by the service quality and operation group.
- The trust was developing a new palliative care electronic patient record on its new Lorenzo system. Further development work was needed before this could be fully implemented. It was envisaged that the new system would flag appropriate patients to the HSPC team and would enable the team to carry out audits of palliative care records.







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- The end of life facilitator was working on a project to develop better links between the emergency department and the hospice for pain management of palliative patients and patients living with dementia.

Appropriate patients were referred to the hospice to be seen the following day with the aim that by working with the patient and their family, further attendances at A&E could be avoided.



# Outpatients and diagnostic imaging

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

## Information about the service

Tameside and Glossop Integrated Care NHS Foundation Trust offered 49 outpatient clinics. The trust reported 426,334 total appointments in the 18 months from November 2014 to April 2016, averaging 23,715 appointments per month.

The hospital offered a combination of consultant and nurse-led clinics for a full range of specialities.

The clinics included rheumatology; urology; respiratory medicine; anticoagulant service; paediatrics; cardiology, ear, nose & throat; dermatology and trauma and orthopaedics.

Across the trust, the top five speciality clinics, by volume of attendance, were trauma and orthopaedics; allied health professional episode (clinics run by allied health professionals such as dieticians; physiotherapists; radiographers and other therapists); obstetrics; dermatology and gynaecology. They made up 43% of all attendances.

Some clinics were “one-stop” clinics and were organised as such that patients could attend their appointment, have associated tests related to that appointment and receive the results and any associated treatment plans and additional support put in place on the same day. This avoided patients having to visit the hospital two or more times before appropriate treatment plans could be arranged.

Most clinics were held in the Hartshead South building. Situated at ground level, it is a modern, clean, brightly lit

extension to the hospital. There was also a separate and secure children’s outpatient department here. Facilities for patients and visitors in the building include, a shop, café, waiting areas, an information desk, a row of reception desks and electronic check-in facilities.

There were further clinics located in the Hartshead North building and positioned because of their proximity to the radiology departments, such as the fracture clinic or breast screening clinic.

There were four separate areas housing the diagnostic imaging services in The Hartshead North building and Ladysmith building. These areas housed plain film x-rays; interventional radiology (IR); ultrasound scans; cardio echography scans; magnetic resonance imaging (MRI) scans; computerised tomography (CT) scans; breast imaging and nuclear medicine.

We inspected these services from 8 to 11 August 2016. We looked at trust documents, made observations and interviewed staff and patients. During the inspection, we visited at least 10 clinics; spoke to 14 patients and 54 staff and reviewed nine sets of patient notes.

# Outpatients and diagnostic imaging

## Summary of findings

We rated outpatients and diagnostic imaging services as good overall. This was because:

- Staff were confident about raising incidents and there were systems in place for feedback and learning from incidents and complaints. The trust had strong arrangements in place to ensure that duty of candour was applied accordingly, in accordance with the Health and Social Care Act 2008 and that patients received an apology, full explanation and were supported going forward.
- Staffing levels were appropriate to meet patient needs although increased demand on radiology services meant that some reporting on diagnostic imaging was outsourced overnight. There was ongoing forward planning on future staffing requirements.
- There were appropriate protocols for safeguarding adults and children and staff followed safety procedures to keep patients safe.
- Equipment was maintained and the environment was clean with steps being taken to minimise infection risks.
- The trust reacted to new guidance and procedures accordingly and were proactive in looking at successful evidence-based care and treatment in other trusts to drive improvements. Audit outcomes were discussed with staff to seek solutions and improve.
- Services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients' wishes into account and confidentiality and privacy was respected. We saw instances of service planning and delivery to meet the needs of local people.
- The trust had made huge improvements in Referral to Treatment (RTT) times and was actively seeking improvements all the time to ensure that all clinical pathways met England standards. The trust was meeting overall RTT times when the service statistics were amalgamated and had not been doing so when we first inspected the trust and figures could not be

accurately produced. They demonstrated that they were good at identifying issues to patient access and flow and seeking long-term patient-centred solutions.

- There was a clear vision and strategy in place for improving the outpatients and diagnostic imaging services with identified problems, proposed solutions, clear targets, future performance measurements and achievements to date.
- Staff were working together to bring about the necessary changes and were engaged. Staff reported that they felt supported, there was visible and competent leadership and that there was an open and honest culture in the trust. The public had also been actively engaged in bringing about service improvements.
- We saw a number of innovative practices to improve services and patient experiences and the trust sought potential solutions by researching with an outward vision and with a mind for minimum disruption to patients.

However:

- The trust had staffing shortfalls in radiologists and were having difficulty in recruiting new staff due to a national shortfall. They were reliant on locum coverage to meet safe staffing levels.
- They lacked an electronic system that could interface with local GP surgeries to enable more efficient GP referrals and reporting of results.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated outpatients and diagnostic imaging services as good in the safe domain. This is because:

- The number of incidents causing moderate harm or worse, was low. Staff were aware of how to report incidents and were comfortable in doing so. There were systems in place for feedback and learning from incidents. Duty of candour was applied accordingly and there was a strong training regime to promote duty of candour.
- There were high levels of compliance with cleanliness, infection control and hygiene throughout the departments and action plans were put in place wherever standards fell short of 100% compliance.
- Equipment was fully maintained and repaired in a timely way. There were maintenance schedules or managed maintenance contracts in place for equipment.
- Medicines were appropriately stored and access restricted to authorised staff. Stock expiry dates were being checked and fridge temperatures were checked and maintained on a daily basis.
- There were very few occasions when patient records were not available at the time of their clinic attendance and processes in place to retrieve the required information where they were not. Case notes that we looked at, in the main, contained expected information and were well kept. They were stored securely.
- Staff followed appropriate safeguarding and safety procedures and escalated concerns or incidents where appropriate and were able to demonstrate that they could react in accordance with the Major Incident Policy.
- Audits were carried out to monitor and maintain patient safety.
- The trust had increased staff to maintain safe levels and there were no nursing vacancies. They were looking to the future and planning what staffing levels would be needed in the short and long-term.

However:

- The trust was struggling to recruit radiologists because of a national shortage and was meeting safe staffing levels by use of locums and seeking solutions with other trusts.
- There was an issue with the recording of mandatory training records for allied health professionals and this was an ongoing issue at the time of our inspection.

### Incidents

- From 1 June 2015 to 31 May 2016 there were 744 reported incidents in outpatients and diagnostic imaging departments at the trust. 677 of these incidents were reported as causing no harm and 55 as low harm.
- In the same period 11 incidents were reported as causing moderate harm. These incidents were reported in radiology: medical records; the vascular clinic; fracture clinic; blood sciences; physio and the gynaecology clinic. Types of incidents ranged from appointment issues; care related issues and there was one pressure ulcer incident reported in the fracture clinic. We were told that, where appropriate, a root cause analysis (RCA) was carried out on these and serious incidents, for example, an RCA had been carried out on the pressure ulcer discovered in the fracture clinic that had been caused by a plaster cast.
- The radiology unit has a duty to protect patients from radiation exposure under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. They reported no radiation incidents in the six months prior to our inspection.
- The Christie Hospital audited radiation incidents.
- There was one major incident recorded as having caused severe harm in the aforementioned period, though this was in July 2015 and related to x-rays. In the year prior to our inspection there had been no serious incidents recorded.
- There were no "Never Events" (very serious, wholly preventable patient safety incidents that should not occur if preventative measures are in place) in the 12 months before our inspection.
- Staff reported incidents via an electronic incident reporting system.
- Staff that we spoke knew how to report an incident on the system and were comfortable in doing so.
- Feedback was given to the person who made the incident report and learning from incidents were discussed at team meetings.

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- Incident reporting, along with complaints and safeguarding referrals, were managed through the trust quality and governance unit and the responsible person. Any incidents identified were triaged every day and if any case was found to have caused moderate harm or above, the duty of candour process was applied. The process was overseen by a lead executive director; the Director of quality and governance and the non-executive lead for the quality and governance committee.
- The trust had a 'Being Open' policy in place that set out the requirements and was aligned to the duty of candour; 'Procedure for Incident Reporting and Managing'; 'Serious Untoward Incident' procedure; 'Investigation and Root Cause Analysis Procedure'; 'Complaints Policy and Procedure and Claims Management Procedure'. This policy was available to all staff via the trust intranet.
- The trust website outlined what patients, carers and relatives could expect when things went wrong.
- All staff were given duty of candour training during corporate induction and a number of measures were undertaken to ensure that existing staff understood the requirements of duty of candour, including posters and leaflets; a podcast and slides on the trust intranet.
- Leaflets were available for patients on duty of candour and investigation of incidents and complaints.
- There was documented evidence of equipment cleaning and "I am clean" stickers were in use.
- Staff in radiology were aware that infectious patients should be isolated and the x-ray rooms were cleaned thoroughly after their treatment.
- Sharps bins were labelled correctly, were not overfilled and were kept closed when not in use.
- Floors, chairs and curtains were covered in a wipeable material and were clean. Curtains were disposable and in date.
- Monthly hand hygiene and bare below the elbow audits held across the trust generally produced 100% compliance in outpatients and radiology, the exception being in March 2016 when outpatients clinics in the Hartshead South building recorded 77% compliance for hand hygiene and 80% for bare below the elbows. Staff failing the audit were identified, reasons for failure given and relevant support and training was given where necessary to prevent further occurrences.
- There were quarterly infection prevention audits in all areas. The last audit in outpatient clinics had shown overall compliance of 97%. The audit was comprehensive. Any areas falling below 100% standard were identified, the issues were stated and an action plan was put in place to bring the area up to the required standard.
- However, we saw that in radiology, positioning aids foam pads were not coated in a waterproof coating. Radiographers were wiping down the pads after use and used a plastic cover if there was contact with bodily fluids or infection. Foam pads are porous and there was a risk of infection if adequate covers were not used.

## Cleanliness, infection control and hygiene

- All outpatients and diagnostics departments inspected were visibly clean and we noted that staff followed good practice guidance in relation to the control and prevention of infection.
- We saw that staff were bare below the elbow in clinical areas, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines on infection control.
- Hand gel dispensers were plentiful and full in all departments and appropriately placed for use by patients and staff
- A member of the cleaning staff told us that the cleaning team had been brought back in-house, having previously been contracted out to a private company. They felt that hospital cleaning rotas were working more effectively, they felt part of the "hospital team" and there was an efficient "deep clean" rota for all areas on a rolling or "as required" basis.

## Environment and equipment

- We saw that resus trolleys were located in outpatient and diagnostic imaging departments. They were clean and in good order, sealed, fully stocked and checked daily.
- The trust had a medical equipment service department that were ISO 9001:2000 quality accredited. They provided a variety of services from advising on equipment purchases to decommissioning redundant equipment. The team maintained equipment in a routine maintenance schedule or managed maintenance contracts with third parties. They also had a repair facility so that equipment could be brought back into use as quickly as possible. An out-of-hours service was available at weekends and on bank holidays. The

# Outpatients and diagnostic imaging

team maintained an inventory of all equipment on site that contained a history of all the work carried out on the equipment whether it be maintenance or repair. They followed guidelines and a code of practice in equipment maintenance.

- All radiology equipment maintenance contracts had been tendered shortly before our inspection and this was an ongoing process.
- We noted that there were appropriate warning signs on doors in radiology with restricted access to areas where there was radiation or high-powered lasers.

## Medicines

- Medicines were appropriately stored and access was restricted to authorised staff. Weekly checks on stock expiry dates took place and short dated medicines were returned to pharmacy.
- Controlled drug stocks were restricted to those areas likely to require their use and accurate records were maintained in accordance with trust policy.
- Emergency medicines and equipment were readily available and there was a procedure in place to ensure they were fit for use.
- Medicines fridge temperatures were recorded daily and appropriate action was taken and recorded when the temperature went outside of the required range. However maximum and minimum temperatures had not been recorded in accordance with national guidance
- Medicines to take home were issued to patients from outpatients or they were provided with a prescription for dispensing by the hospital pharmacy department. Non-urgent medicines were recorded on a form that was given to the patient to take to their GP Practice for them to prescribe.

## Records

- Patient records were not available in clinic in only 0.4% of cases.
- Case notes were tracked electronically on a bespoke system. There was additional tagging that enable users to easily identify any additional movement and this could be used to find case notes if they had been tracked incorrectly or not at all.

- In the event that case notes were not available in a clinic staff were able to obtain referral letters, previous clinic letters, discharge summaries and accident and emergency records and results from the Lorenzo system.
- Radiology staff were able to access any existing images via the Picture Archiving and Communications system (PACS).
- In the event that a set of case notes could not be located in clinic (that happened rarely), staff would create a set of temporary notes, incorporating any previous relevant information and any clinical documentation created during the consultation. These would then be incorporated into the case notes once located.
- If the consultant or patient was unhappy to proceed with the consultation without the full set of case notes, the patient would be given another appointment.
- The trust undertook audits of case note availability in clinics.
- We looked at nine sets of patient notes. These showed that there was a named consultant; an individualised care plan; the notes were legible and signed and dated; appointment details were given and the next appointment due date was indicated. In addition, where appropriate, case notes reviewed other prescribed drugs or medicines. One set of notes was not signed and dated for each entry. Where appropriate, notes outlined co-ordination with other outpatient clinics and highlighted where a chaperone was required. We did not see any notes where any patient allergies had been recorded. The notes were stored securely in clinic.

## Safeguarding

- Overall in the trust there was an executive lead for safeguarding and a management leading who was also the chair of the 'Internal Safeguarding Group'.
- Outpatient clinics had a safeguarding adults lead (a band 6 sister) who provided management of safeguarding issues at a local level. They reported that they had good access to, and support from, the trust's safeguarding team.
- The safeguarding lead had devised a flow chart which details key contacts and how to access local Police support and agencies should any suspected cases of forced marriage or human trafficking emerge. This had been disseminated to staff.

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- The trust had introduced classroom training in addition to e-learning for administrative staff undertaking safeguarding training.
- All staff in outpatients and radiology were trained at level two for adult safeguarding and level one for safeguarding in children. Band 6 and above staff had been trained in level three adult safeguarding.
- The trust had recently introduced the requirement for staff in outpatients and radiology to undertake level two children's safeguarding. In June 2016, 97% of administrative and clerical staff in the directorate had undertaken safeguarding children training; 34% of medical and dental staff and 39% of nursing staff.
- In June 2016, between 99%-100% of all staff in the directorate had undertaken safeguarding adults training. The trust target was 95%.
- Infection prevention had been undertaken by 89% of administrative staff; 84% of medical staff and 88% of nursing staff.
- Resus training had been undertaken by 89% of medical staff and 85% of nursing staff.
- E-manual handling had been undertaken by 92% of administrative staff and manual handling practical had been undertaken by 83% of medical staff and 82% of nursing staff.

## Assessing and responding to patient risk

### Mandatory training

- Mandatory training was delivered by a mixture of e-learning and face-to-face training. Trust target for each mandatory training course was 95%.
- Mandatory training for all staff included information governance; equality and diversity; health and safety; fire; infection prevention; resus; e-manual handling and manual handling practical.
- At the time of inspection there was an issue with trust reporting tools for allied health professionals and they were unable to report the training levels for them. This issue had been ongoing for a while. The trust were unable to give us an accurate breakdown of staff in outpatients and radiology who had completed each course because of this.
- With regard to other staffing groups within the directorate as a whole, in June 2016 87% of admin and clerical staff had undertaken information governance training, along with 83% of medical staff and 74% of nursing staff.
- 97% of administrative staff; 95% of medical staff and 98% of nursing staff had undergone equality and diversity training.
- Health and safety training had been taken by 97% of administrative staff; 88% of medical staff and 92% of nursing staff.
- Fire safety training had been taken by 94% of administrative staff; 93% of medical staff and 88% of nursing staff.
- The WHO (World Health Organisation) Checklist identifies three phases of a procedure, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia or other drugs ("Sign In"); before the commencement of the procedure ("Time Out") and before the patient leaves the procedure room ("Sign Out"). In each phase, a checklist co-ordinator must confirm that the team has completed the listed tasks before it proceeds with the procedure. It is designed to minimise patient risk and avoidable harm whilst undergoing a procedure. The radiology unit was using the WHO checklist for radiological interventions.
- We saw that the radiology reports did not generate a flag on the Lorenzo system to indicate that the image reports had been received and read by the referrer so the PACS manager was unable to determine whether there had been delays or were potential delays in delivering results to patients, consultants or GPs. This had been highlighted as a concern by the trust.
- We observed that the radiology department used a comforters and carers book. This was in response to guidance on effective radiation dose limits for comforters and carers who may accompany a patient into an x-ray or scanning room as per the Ionising Radiations Regulations 1999. Records of doses received and the person receiving them were kept and audited so that the same person was not routinely asked to assist the patient and receiving an additional dose of radiation unnecessarily.
- There were radiation protection supervisors for each imaging modality and there was a radiation protection adviser from The Christie, Manchester. Radiation protection supervisors produced an annual report that outlined patient and staff exposure risks and how they would be minimised.
- The Radiation Protection Committee at the trust (made up of lead radiographers and radiology managers) met



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quarterly to discuss and minimise patient and staff risks. In January 2016 they reported that, due to workload increases across the department they were carrying out 0.8 examinations per week higher than the recommendations on the risk assessment. The trust took action to monitor the situation and review the risk assessment.

- Staff were able to describe the procedures and escalation they would follow if a patient became acutely unwell and, at the time of inspection a high proportion of medical and nursing staff had undergone resuscitation training. This was ongoing.
- The trust had a Managing the Deteriorating Patient Group who were the work stream lead committee for the acutely unwell and deteriorating patients for the trust's Patient Safety Board Programme. The group had introduced the National Early Warning Score (NEWS) designed by the Royal College of Physicians. The purpose being, to ensure timely recognition and escalation of the acutely unwell patient. The work carried out by the group responded to National Institute for Clinical Excellence (NICE) Guideline 50. NEWS had been in use by the trust in outpatients and radiology since October 2014 and was embedded in the working practices. Compliance had been audited shortly before our inspection but the results were unavailable at the time of inspection.
- We saw that 'Local rules for Radiation Protection' were dated from January 2015 but there was no version control and the staff signatures, indicating that they had read and understood the rules, were not up to date. The service lead agreed to review the situation.

## Nursing staffing

- There were no nursing staff vacancies in outpatients at the time of inspection.
- From January 2016 to April 2016 the qualified demand for registered nursing staff in outpatients was 15.00 whole time equivalent (WTE) and the trust had 14.20 WTE nursing staff in post.
- The trust used an e-rostering acuity tool to ensure that nurse staffing was matched with clinical activity. There were weekly planning meetings to ensure that clinics would have adequate nursing cover.
- At times, additional nursing staff, over and above establishment, were required to work on extra clinics, for example, to reduce waiting lists clinics were

occasionally added during the week or on Sunday. The trust used NHS Professionals agency staff on occasions to fill clinics but they were staff who already worked for the trust.

- From January to March 2016 there was an unqualified demand for 44.40 healthcare assistants (HCAs) in outpatients and the trust had 34.80 in post with vacancies for 9.60 WTE staff. The number in post included 3.8 assistant practitioners. In April 2016 the actual versus establishment rate for healthcare assistants varied by 10.50.
- The trust recognised that some nurses were coming up to retirement and were forward planning about future recruitment of band 3 and 4 nurses and upskilling of those healthcare assistants who were interested in qualifying as nurses. They also recognised that they would need more HCAs and were working with a local college to recruit assistant practitioners who could move on to become HCAs in the future.

## Allied Health Professionals

- The trust had been affected by a national shortage of radiologists and had four full time in post against an establishment of 9.1 WTE. Safe staffing levels were maintained and the variance had been reduced, by the use of locum staff. A mix of NHS and agency staff had been there some time so that the trust was working with a staffing of 8.8 WTE radiologists. This reduced the variance to -0.3.
- The trust was actively recruiting and was looking abroad to fill the vacancies.
- The trust was also working with another trust to consider how rota gaps could be filled between the two trusts by working together and patients receiving surgery at the other trust who had been referred by Tameside would be likely to have diagnostic scans there too.
- The trust was upskilling radiographers in different areas so they could cover more varied reporting types when required, such as virtual post-mortem CT scans and overnight reporting was outsourced to a UK-based company.

## Medical staffing

- There was no specific medical consultant cover in outpatients. Instead, outpatient clinic sessions were incorporated into speciality specific job plans of

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consultants working in surgery; medicine; maternity & gynaecology and children & young people. Details of medical staffing and cover is found in the location reports relating to these core services.

- There were no consultants in the trust working in urology and the trust had a service level agreement for urology clinics to be delivered by consultants from another Greater Manchester trust with any required surgery taking place at the other trust. The service level agreement was not being fully delivered due to lack of consultant capacity. The trust had requested the delivery of two further clinics per week but the delivering consultants could only provide one further clinic per week. The trust were actively seeking solutions to minimise the need for patients to travel long distances for their appointment but the plans did not immediately involve the recruitment of any urology consultants.

## Other staffing

- The trust had increased the number of booking clerks from eight to 16 to make the booking process more efficient and ensure that patients were given timely appointments.
- The medical records department were in the process of recruiting five additional staff to ensure that patient medical records across the trust were managed and maintained safely and effectively.

## Major incident awareness and training

- The trust had a Major Incident Policy and this contained details about the suspension of outpatient clinics and elective activity in the event of a major incident.
- The trust had held simulation exercises to ensure that the plan reflected what would happen.
- During our inspection, a major incident happened close to the hospital in the early morning. Managers told us that a team was in place by 7am ready to start calling patients and cancelling clinics. A team of surgeons and orthopaedic trauma specialists were also on site in the event that urgent surgery was required. Fortunately, the number of casualties did not require the cancellation of clinics or elective surgery though we saw that the radiology coped well with a number of urgent patients needing x-rays following glass impact injuries.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the effective domain. We found:

- There were procedures in place for ensuring that new guidance was assessed and disseminated to staff with appropriate training given as soon as practicable.
- The trust were proactive in looking at successful evidence-based care and treatment in other trusts in order to drive improvements.
- Pain relief was available to patients when required.
- New to follow up rates for outpatient appointments were in line with expected ratios.
- Every patient on a treatment pathway had an outcome form on their records so that intended outcomes and required tests, expected result dates and the results could be recorded.
- There were audit plans for both the outpatient and radiology services.
- Radiology services received audit days to receive audit results and discuss outcomes.
- The trust worked with other trusts to upskill staff and staff were encouraged to take up training opportunities to increase their competencies.
- We saw evidence of staff working well together as a multidisciplinary team.
- Staff were adequately trained in the Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- The trust lacked an electronic system that could interface with local GP surgeries to enable more efficient GP referrals and reporting of diagnostic results back to GPs.

## Evidence-based care and treatment

- Patients had their needs assessed and care planned and delivered in line with evidence-based guidance, standards and best practice.
- The governance team sent out any new evidence-based guidance, such as NICE guidelines and patient safety

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alerts. Divisional governance meetings for outpatients and diagnostic imaging discussed whether the guidance was applicable and specialist nurses were responsible for introducing and training staff on new guidelines.

- The trust were proactive in looking at successful evidence-based care and treatment in other trusts in order to drive improvements for example, in introducing a “Virtual Fracture Clinic” they had looked at a model of care in another trust where they had reduced unnecessary patient attendances at a fracture clinic by 20%.
- The trust used the five steps of safer surgery protocol that ensured that minor procedures carried out complied with NICE guidelines.
- Nursing and medical staff were aware of the relevant guidance to their clinical area and knew how to access guidance on the trust intranet.
- The needs of people living with dementia were considered in planning care and treatment and there was a specialist dementia nurse to offer more expert advice.

## Pain relief

- Pain management was discussed with patients when applicable to them. This was especially after any invasive procedures that they may have undergone.
- Opioid drugs were available for pain relief in radiology for those patients who had undergone interventional procedures.
- Patients requiring pain relief whilst in clinic could bring their own medication that was reviewed by medical staff, as appropriate.
- Analgesia and topical anaesthetics were available to children who required them in the outpatients department.

## Patient outcomes

- The trust’s outpatient follow-up to new rate was 1.98 between March 2015 and February 2016. This has been consistently slightly lower than the England average.
- From 1 April 2016 to 29 May 2016 33.1% of outpatient appointments were for new patients and 66.9% were follow-up appointments. This was in line with expected ratios.
- Every patient on a treatment pathway had an outcome form on their records. This was updated by the nurse or consultant at each appointment and detailed when test results could be expected and what further tests were

needed. It enabled patients to book a diagnostic test whilst at the hospital and there was an “Awaiting Test Results” list in line with when expected outcomes were due, so follow-up appointments were not made before results had come back.

- The outpatients department participated in a local audit programme. There were planned audits on the Chaperone Policy and clinic documentation. There was also participation in trust wide audits on the WHO surgical checklist for interventional procedures taking place outside theatres; National Early Warning Scores (NEWS) audit and an audit on consent.
- The radiology department carried out numerous clinical audits in all modalities, examples of which were compliance with the seven point ID check; GP satisfaction audit; WHO checklist compliance rates; report turnaround times to GPs; claustrophobia audit on the CT scanner; daily storage of isotopes radiology booking office and whether it has made a difference and radiation protection.
- The radiology department held audit days for staff to present results and feedback from each audit. The last radiology audit day had been held in May 2016 when five presentations were given to staff.
- The Outpatient Improvement Project was focussed on patient outcomes and improving patient experience. It had been assessed as to whether the proposed improvements would have a positive impact on enhancing the quality of life for people with long-term conditions; supporting people to recover from episodes of ill health; ensuring a positive patient experience and providing a safe environment free from avoidable harm.

## Competent staff

- The trust was working together with a neighbouring trust under the “Healthier Together” programme to upskill radiographers across both trusts. Consultants had time factored into their job plans to mentor radiographers.
- The trust target for delivering appraisals was that 95% of appraisals had to be delivered by 31 August 2016. Staff that we spoke to told us that they had received an appraisal and managers in all departments told us that they had or would meet these targets. The surgical division (in which outpatients and diagnostics sat) had carried out 95.6% of appraisals overall at the time of our

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inspection. Outpatients was at an 80% completed figure at the time of our inspection but appraisals were ongoing and managers were confident that the target would be met by the end of August 2016.

- Managers told us that trust and departmental objectives were rolled down through the organisation and that trust values and beliefs were also embedded in the appraisal system.
- The trust used the iHeart nursing e-portfolio revalidation system and we were told by managers that this had achieved high levels of nurses revalidating in good time. The trust had a facilitator who supported the process.
- All health care assistants were undergoing a new care certificate programme. This was a week long course for new starters as part of their induction. Existing staff were undertaking the course on a rolling programme over a three-month period. A preceptorship lead was supporting the programme.
- Band 5 nurses had the opportunity to carry out pre-operative training leading to an upgrade to band 6. They were able to take on some of the role of a consultant anaesthetist to make the clinics more nurse-led. Nurses also had the opportunity to undertake colorectal and neck of femur advance recovery training.
- Staff were encouraged to undertake courses to improve their competencies under the training and development budget.
- We were given examples of staff who were undertaking further training or development, such as, a staff nurse who was developing ear suctioning; two nurses who were job shadowing and working with community tissue viability nurses; a sister completing a degree course in modules; cannula training for nurses and a staff nurse and sister who were undertaking a mentorship course.
- Staff were also encouraged to go to other trusts for job shadowing opportunities.
- Administrative staff had all undergone customer service training.

## Multidisciplinary working

- In radiology, the trust was working with radiologists in a neighbouring trust under the “Healthier Together” programme in order to fulfil a seven day rota. As some patients were to receive their surgery at the neighbouring trust, it made sense for their diagnostic tests to be carried out there also.

- Service level agreements were in place with other trusts to deliver services, for example, for urology surgery that took place at a neighbouring trust. However, in that instance, the terms of the service level agreement had never been completely fulfilled as the neighbouring trust had been unable to offer the agreed number of clinics per week. Renal, neurology and neurophysiology operations for Tameside residents took place at another trust but the consultants led clinics for those patients on site at Tameside.
- The trust was effectively using the expertise of specialists in other hospitals to improve their patients’ care.
- Specialist nurses told us that they were part of Manchester-wide groups and were able to share knowledge and information with their peers and discuss patient care and treatment needs.
- Consultants in outpatients were working together with some local GPs with a view to GPs becoming more involved in giving advice and guidance to patients on their necessary treatment and some clinics being delivered in the community by consultants in health centres.
- We saw effective working between consultants, nurses, allied health professionals and administrative staff to deliver one-stop clinic services, such as the head and neck and breast clinics.
- Staff reported that there was good communication with GPs and district nurses to provide follow-up care to patients.
- We saw evidence that staff in the suspected cancer clinics worked well with Macmillan nurses to arrange follow-up support at the earliest opportunity when cancer was confirmed.
- Staff told us that they felt part of a wider team, working together to improve patient care and treatment.

## Seven-day services

- Outpatients did not run a seven-day service as the norm. Clinics ran from Monday to Thursday from 8am until 8pm and 6pm on a Friday. Clinics were also run on a Saturday from 8am to 4pm. Clinics were run on Sundays as an exception to alleviate waiting lists.
- Radiography tests were available seven days per week and 24 hours a day. There was consultant radiologist on site from 8am until 5pm and on-call from 5pm overnight.

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- Reporting of radiology films was outsourced overnight. This was carried out by a UK based company using night workers, having previously been outsourced to a company in Australia.
- Cancer scans were not generally outsourced unless there was an urgent need.

## Access to information

- The trust had access to a new Picture Archiving and Communications system (PACS) across Greater Manchester that allowed access and transfer of diagnostic imaging between trusts.
- Patient details, pathways and appointments were accessible at point of care on the trust wide Lorenzo system.
- At the time of our inspection the trust had no system that could link to the EMIS system, used to record and share information with primary care services to provide an integrated care system. They were preparing to tender for a system that would integrate with the system used by local GPs so that GPs could refer a patient electronically and the information would populate the trust system ready for triage.
- There was an electronic patient tracking system so staff were able to locate patient notes easily.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had planned an audit on taking patient consent and there would be ongoing monitoring of whether consent from patients was being sought and recorded correctly.
- The Mental Capacity Act (MCA) is in place to protect and empower individuals who may lack mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. The Deprivation of Liberty safeguards (DoLS) aim to protect people who lack mental capacity, but who need to be deprived of liberty so that they can be given care and treatment in a hospital or care home. Training on DoLS was available to all staff in outpatients and Mental Capacity Act training formed part of mandatory training.
- Nursing and medical staff told us that they had completed training in assessing the mental capacity of patients prior to consenting treatment. Staff were able

to tell us about holding multidisciplinary best interest meetings to decide the best course of action where a patient lacked capacity. Carers and relatives were involved in the decision making process.

- Mental Capacity Act and DoLS policies were in place.
- During our last inspection, we found that staff in the phlebotomy department had not received training in the Mental Capacity Act or DoLS. We were told that all phlebotomists had now received the relevant training and were comfortable in the processes of seeking consent or holding best interest meetings to ensure that taking blood (an invasive procedure) was carried out with patient consent or was in their best interests where they lacked capacity.

## Are outpatient and diagnostic imaging services caring?

Good



We rated outpatients and diagnostic imaging services as good in the caring domain. This is because:

- Kind, caring and compassionate staff delivered outpatient and diagnostic services at Tameside General Hospital. They were observed to be polite, friendly, helpful and made efforts to alleviate patient fears. Bad news was delivered in a clear and supportive way and further support for cancer patients was put in place before the patient left the clinic.
- Healthcare assistants were undertaking a care certificate training programme to improve communication and caring for patients.
- Staff recognised people needing additional support and made every effort to facilitate and meet their needs. Provision was made for patients to have a family member, carer or chaperone accompany them.
- Patients told us that they received clear information before, during and after their appointments and knew what to expect. Follow-up appointments could be arranged before the patient left the clinic.

However:

- We saw that privacy and dignity was not always maintained in the CT scanner waiting area where there



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were inpatients on trolleys and in Clinic nine there was a consultation room with an outward-opening door where the patient could be seen in the room when the door was opened.

- There was a risk that private conversations could be overheard in some clinics when a patient was at the reception desk.
- Access to PALS was not clear to most patients attending appointments, should they have a complaint.

## Compassionate care

- Patients told us that staff were helpful, kind and caring and introduced themselves.
- We saw staff offering assistance to patients or visitors who needed directions or assistance in the hospital corridors.
- Medical, nursing and administrative staff spoke respectfully to patients.
- We observed that staff were friendly and supportive and reception staff were knowledgeable and able to help patients with queries other than about their outpatient appointment.
- All consultations and examinations took place in a closed examination room or in a cubicle with closed curtains. There was appropriate signage on the doors to indicate when a room was in use. This assures us that patient dignity and privacy was maintained.
- The hospital had a chaperone service and patients with carers were encouraged to bring their carer to appointments. A sticker or a stamp on the front of their file identified patients who required a chaperone when they attended on a regular basis. One patient that we spoke to described the chaperones as “lovely”.
- There were mixed sex ward patients waiting on trolleys in the CT scanner waiting room with outpatients. Staff had tried to address the issue of the lack of dignity this presented with the use of mobile screens. However, this in turn presented a safety issue as the inpatients could not be observed at all times. Two patients that we spoke to expressed a dislike for there being inpatients waiting on trolleys in the same area.
- Some reception areas in outpatients clinics in the older, Hartshead North building, had chairs that were close to the reception desk so there was a risk that service users could be overheard whilst giving personal details to a receptionist.

- We did not see any barriers or a sign at reception desks telling people to wait a certain distance away until the next receptionist was free. However, in the Hartshead South outpatient reception area there was a row of staffed reception desks and no queues.
- In clinic nine, ultrasound room, the door opened outwards and the patient could be seen inside the room when the door was opened. This was brought to the attention of staff at the time. There were no curtains that could be pulled across clinic doors when there was a patient in the room to protect dignity if the door was opened during a consultation.

## Understanding and involvement of patients and those close to them

- Most of the patients that we spoke to told us that they would know who to contact if they were worried about their condition or treatment after they left the hospital.
- We observed a patient pathway through the head and neck clinic and saw that a full explanation of the planned procedures was given to the patient and they were able to have a companion with them during tests. Because it was a one-stop clinic, it was explained that the patient would receive the necessary scans after the consultation and then return to the clinic later to receive the results.
- All health care assistants were undertaking a new care certificate training programme to improve communication skills and showing respect and dignity. For new staff members the programme was a week-long course.
- Staff demonstrated that they recognised when people needed additional support, for example, a patient had attended during the week of our inspection who was very scared of hospitals and wanted to be in the building for as short a time as possible. This was facilitated so that they were seen straight away. Staff also gave an example of nursing staff making tea and toast for a vulnerable patient who attended the hospital every day.
- Patients told us that staff kept them informed about any delays in a clinic and there were screens in clinics with information about waiting times and delays. Snack boxes, containing a sandwich, drink and biscuits were available to patients who were experiencing delays, had diabetes or were waiting for transport home.



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- A Patient Satisfaction Survey conducted in May 2016 received 694 responses. 93% of responders said that letters and any leaflets received regarding their appointment were clear. 95% of responders said that they felt prepared for their appointment.
- As far as possible, those patients who required additional support or more bespoke care were identified as such by means of a sticker on the front of their file, for example, those patients who were living with dementia or who had learning disabilities.
- There was ongoing work with local GPs to improve communication with patients on suspected cancer so that GPs explained to the patient why they were on a two-week wait pathway and what they could expect when they attended their hospital appointment.
- Patients were given appropriate follow-up appointments. Consultants explained when test results could be expected and when they needed to see the patient again. A sheet containing these details was given to the patient and a follow-up appointment could usually be booked at the in-clinic “check-out” reception on the way out, as opposed to the general outpatient “check-in” desks.
- Only one of the patients that we spoke to was aware of where to complain if they felt it necessary to do so.
- We spoke to an inpatient in radiology who was not aware of the treatment they would receive or why they had been brought to the department.

## Emotional support

- Patients that we spoke to who required emotional support, all reported that this was adequate.
- We observed a patient being given test results and an action plan as to what should happen next. This was given in a supportive manner and was a good demonstration of breaking bad news. Before the patient left the clinic a further consultant appointment and support from Macmillan nurses was arranged.
- There were three interview rooms available in outpatient clinics that could be used for delivering bad news or where patients could spend time with carers and relatives if required.
- In the CT colon clinic, the radiographer held a pre-procedure preparation with patients where they sat down and talked through the process and what they could expect.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated outpatients and diagnostic imaging services as good in the responsive domain. This is because:

- The trust offered a number of one-stop clinics to patients.
- The trust was working with local GPs to plan clinics that could be delivered in the community.
- Out of hours clinics and clinics run on a Saturday were available to patients and occasionally Sunday clinics were put on to alleviate waiting lists.
- Self-check-in kiosks were available to patients and waiting times in clinics were mainly short.
- Information given to patients was clear and informative and additional information could be supplied. Information was available in different languages.
- There had been significant improvements in referral to treatment (RTT) times since the introduction of an RTT and data quality team and the trust was proactively seeking solutions to improve waiting times so that all services met England standards. The trust was meeting RTT standards when all service statistics were amalgamated. RTT times were monitored constantly to keep breaches at a minimum.
- The trust was consistently better than the England average on cancer waiting times and were above the England standards.
- There were adequate adjustments made for people whose first language was not English, for people with disabilities and for patients living with dementia and learning disabilities.

However:

- The trust acknowledged that they experienced issues with RTT times in certain clinic services, such as Urology and with in-clinic waiting times such as the fracture clinic. They were actively seeking solutions to these, such as introducing the “Virtual Fracture Clinic”.
- The trust still had concerns over Did Not Attend (DNA) rates that were higher than the trust target of 9.5%. The trust were improving clinic bookings, reminder services and looking for clinics that could be run in the community to improve these rates.

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## Service planning and delivery to meet the needs of local people

- Tameside and Glossop Integrated Care NHS Foundation Trust offered 49 outpatient clinics. The trust reported 426,334 total appointments in the 18 months from November 2014 to April 2016, averaging 23,715 appointments per month.
- The hospital offered a combination of consultant and nurse-led clinics for a full range of specialities.
- The clinics included rheumatology; urology; respiratory medicine; anticoagulant service; paediatrics; cardiology, ear, nose & throat; dermatology and trauma and orthopaedics.
- Across the trust, the top five speciality clinics, by volume of attendance, were trauma and orthopaedics; allied health professional episode (clinics run by allied health professionals such as dieticians; physiotherapists; radiographers and other therapists); obstetrics; dermatology and gynaecology. They made up 43% of all attendances.
- Some clinics were “one-stop” clinics and were organised as such that patients could attend their appointment, have associated tests related to that appointment and receive the results and any associated treatment plans and additional support put in place on the same day. This avoided patients having to visit the hospital two or more times before appropriate treatment plans could be arranged.
- Examples of “one-stop” clinics were the head and neck clinic, held on Wednesday mornings, and breast clinics. The head and neck clinic was held in a clinic area adjacent to the CT scanner location so that patients could easily move between the two to have diagnostic scans and then return to the clinic to receive their results.
- The trust were working with a local specialist cancer trust to build a new cancer centre at Tameside General Hospital meaning that Tameside residents could receive cancer treatment at their local hospital rather than having to travel across Manchester.
- The Referral Management Group was working with two local GPs to plan clinics that could be held in the local community. The trust was piloting putting Consultants in neighbourhood clinics and consultants and GPs working together to give advice and guidance to patients. The group was working together on a new referral form that increased patient choice for patients about location of appointments and was easier to use for patients with learning disabilities.
- Out of hours clinics were accessible from Monday to Thursday until 8pm and 6pm on a Friday. Clinics were also run on a Saturday from 8am to 4pm. Clinics were run on Sundays as an exception to alleviate waiting lists.
- The radiology department offered a “Virtopsy Service”. This virtual post-mortem service was used when a CT scan could determine the cause of death. This speeded up the process of determining cause of death and respected the religious and cultural needs of some of the local population. Scans were carried out at night and reporters were experts in reporting on virtual post-mortems. Deceased persons were transported to the unit via a private corridor.
- A new MR scanner had been installed that had a wider opening. This had reduced the numbers of people hitting the red button to stop the scan due to claustrophobia. Patients could also bring their own music to listen to during the scan. Numbers of patients stopping the scan had fallen to 0.6% from 1.4%.
- Outpatient and radiology departments within the hospital were clearly signposted. There were volunteers working in the main outpatient reception area who could assist patients in getting to the right waiting area or using the electronic check-in machines. In the Patient Satisfaction Survey conducted in May 2016, 95% of patients who responded said that they were able to find the location of their appointment with ease.
- Rather than speak to a receptionist, the trust also offered outpatients the option of using self-check-in kiosks on arrival. The kiosks were located in the entrance to that Hartshead North and South buildings. The Patient Satisfaction Survey conducted in May 2016 showed that 36% of responders had used this service.
- The outpatients’ area in the Hartshead South building (the blue clinic area) was bright and airy with plentiful seating arranged so that patients could sit outside the appropriate clinic area. Toilets were clearly signposted and drinks were available for patients, in addition to snack boxes for those patients who required something to eat or were experiencing longer waits for test results or patient transport.
- The paediatric outpatient area was well-signposted, secure and very light, bright and airy. There was large children’s play area that was staffed by play specialists.

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- The hospital produced an outpatient information leaflet that was clear and informative. It covered subjects such as how to arrange for an interpreter; how to cancel or re-arrange an appointment; providing consent; getting to the hospital by public transport; car parking facilities and charges; where to report to; how long you may be in the hospital; what happens after the appointment and details of patient support services, such as PALS, the chaplaincy and Health Information Centre.
  - The Health Information Centre was located in the foyer of the Hartshead North building and was open Monday to Friday from 9am to 5pm. The service was for patients, carers and family members and was able to offer leaflets on all key health conditions; details of national and local support groups; internet-based health information; information on services and support provided by Tameside Council and information in a range of community languages and other formats. There were staff on hand to facilitate requests and they could be made remotely by email or telephone with information posted out. The trust and the local authority jointly funded the Health Information Centre.
  - Buses to the hospital entered the hospital grounds and stopped right outside the main Hartshead North building, however, one patient told us that they had to catch three buses to get to the hospital and another told us that there was no information on which bus to catch to the hospital on the appointment letter.
  - Most of the patients that we spoke to said that parking was available though one complained about the cost of parking and another said that it was difficult because the car parks were always full.
  - In outpatients' clinics six to nine we observed that a small children's play area in the corner of the waiting area had been sectioned off using waiting room chairs facing outwards. This meant that children were playing directly behind adults waiting for their appointments that could have been disturbing to patients and also, if the chairs were occupied, the children could not easily be observed to ensure that they were playing safely.
  - The team had made visible and impressive improvements to RTT waiting times at the trust and were managing information at patient level. In terms of RTT standards the trust was now at mid-table level in terms of achieving standards and had previously been in the bottom six trusts. We were told that a follow-up peer review carried out among 20 trusts by Dr Foster (who produce comparative information about healthcare quality) showed that the trust had risen to 10th place out of the 20 trusts in terms of RTT times for incomplete pathways. They had previously been the worst performing of the 20 trusts in the peer group.
  - We were shown a storyboard that demonstrated the improvement journey for the trust in terms of referral to treatment times. This showed that in February 2014 there were 10,500 patients who were seen in that month and had breached their "See By" date. In April 2014 the trust was two months behind in reporting on monthly RTT data. By comparison, in May 2016 there were 356 patients who had breached their "See By" date out of 25,507 total appointments. This equated to 1.40%. Data could also be reported in real time.
  - The data quality team used dashboards to display up to date information around RTT times and patient pathways. These were also in use in relevant departments across the hospital so that managers could exercise some control and have ownership of patient access and flow and react to any bottlenecks.
  - All patients who had been added to the waiting lists the previous day had their record checked to ensure that RTT waiting times and coding were correct and any listed procedures were appropriate. They also examined the case notes of all patients removed from the waiting list to ensure that there had been no mistake.
  - The RTT and data quality team worked closely with the admin scheduling team to ensure that appointments were made according to urgency and the likelihood of breaching standard waiting times. Patients who had been on the waiting lists for 16 weeks were identified and prioritised.
  - Information derived from examining patient tracking information drove the weekly steering group on patient pathways and waiting times. A record and analysis of any issues or bottlenecks in the system was kept so that lessons could be learned from these and solutions delivered quickly if the same issue was identified again.
- Access and flow**
- The trust had put in place and embedded a Referral to Treatment (RTT) and data quality team, with an experienced manager and team members, in response to CQC recommendations raised in previous reports and the inability of the trust to report RTT data accurately.

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- In May to June 2016, 50 extra clinics had been scheduled to prevent future backlogs and breaching of RTT times when consultants were going on annual leave.
- From March 2015 to February 2016, the trust cancelled 4.5%-6% of clinics with more than six weeks' notice and 1.5% to 2.4% of clinics with less than six weeks' notice. Where cancellation was due to annual leave, extra clinics had generally been put on in advance of that leave. Clinics cancelled with less than six weeks' notice had to be authorised by the business manager.
- The trust was meeting national targets for referral to treatment times (for non-cancer patients) for incomplete pathways. At the time of inspection (August 2016), across all pathways, there was an average of 93% RTT compliance against a national RTT target of 92% of patients to be seen within 18 weeks of being referred. The trust was in line with the England average consistently.
- However, across the 16 reported pathways, in August 2016, five pathways were not meeting the standard target of 92%. These were urology; trauma and orthopaedics; neurosurgery; plastic surgery and geriatric medicine.
- In trauma and orthopaedics 87% of patients referred were seen within 18 weeks. However, the trust had identified that the fracture clinic was very busy and this was impacting on RTT and in-clinic waiting times. They had sought solutions to improve these. They were working with radiology to improve flow and were training two further plaster technicians, however, there was an issue with courses around the country being full until after March 2017. The trust had employed the people with the right skills to improve patient flow but needed to get them properly certificated. They could only carry out processes under supervision at the time of our inspection. They had started to use boots instead of ankle or lower leg casts to speed up the process of removing healing supports.
- The trust was about to start operating a "Virtual Fracture Clinic" at the time of our inspection. Patients presenting with various fractures would be triaged, following an x-ray, to determine which of six different pathways they fell into. This would enable the trust to decide whether they needed to attend the fracture clinic or whether further treatment in A&E was appropriate. The trust had studied another trust where this "Virtual Fracture Clinic" had reduced patient numbers in the fracture clinic by 20% and were expecting similar results.
- For suspected cancer patients, there was a national target of a two-week wait from referral (usually by a GP) to first appointment. This target was set at 93% of patients to be seen at their first appointment within this period. The trust was meeting this target, having seen 94.5 % (749 out of 793 patients) in the month of our inspection (August 2016).
- For two week wait breast symptomatic cases, where cancer was not initially suspected, 94.9 % of patients were seen within two weeks in August 2016.
- For suspected cancer patients, the overall decision to treat to the time of first treatment in the trust was 100% against a target of 94% to be treated within 31 days (one month) of diagnosis. This included patients treated by surgery and anti-cancer drugs.
- For suspected cancer patients with a target of two months between GP urgent referral and time of first treatment there was a target of 85%. The trust had seen 94.8% of these referrals within the expected period within the month of our inspection.
- The trust was consistently better than the England average on cancer waiting times.
- The trust was developing a suspected cancer follow-up waiting list with a tracking system, in order to give appointment priority to cancer patients.
- The trust highlighted the urology service as being a concern to them. There were no urologists employed at the trust. Instead, the service was consultant-led by another trust that held clinics at Tameside General Hospital. The service level agreement had never been fulfilled, as there was not enough capacity to run the required number of clinics. This has resulted in patients waiting up to 19 weeks for the first appointment with only 89.9% of patients seen within 18 weeks against the national target of 92%. The trust had requested an extra two clinics per week to be provided but had only been offered one extra clinic per week. However, we were assured that the trust was actively seeking a solution by looking at other options that minimised the need for patients to travel to another trust to receive treatment. The issue had been escalated and was being researched at director level.
- We were assured that the trust was proactively seeking solutions to improve patient access and flow and meet referral to treatment standards.
- The trust carried out audits of clinic start times monitoring the time the first patient was booked, the doctor arrival time; time the first patient was seen

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(whether this was on time; one to nine minutes late or 10 or more minutes late) and the time that the clinic finished. This helped them to identify whether there were any clinics that consistently started late or overran and seek solutions. The latest audit showed that 82% of clinics started on time or within 10 minutes and 89% of clinics started on time or within 15 minutes.

- Booked appointment time to called time were recorded and monitored by the trust. Records provided by the trust show that in outpatients, in the six months from November 2015 and April 2016, two months had a median wait time of three minutes; two of two minutes and two months had a median wait time of one minute.
- Diagnostic waiting times in the trust were consistently better than the England average for the percentage of patients waiting more than six weeks for diagnostic results. For example, in April 2016, just under 1% of patients waited longer than six weeks whilst the England average was around 1.8%.
- Reporting times for radiology had improved in some areas in the six months from November 2015 to April 2016 but worsened in other areas. For example, urgent requests for radiology results in this period had improved from 63.8% being reported within 24 hours in December 2015 to 96.5% being reported in less than 24 hours in April 2016. However, figures for urgent CT scans reported in the same six month period had worsened from 8.7% reported in less than 24 hours in November 2015 to 1.7% reported in less than 24 hours in April 2016. However, the trust had introduced a key performance indicator on clinical justification that meant that the aim was to report on all suspected cancer urgent referrals within one working day while other urgent referrals had a reporting target of three working days.
- Across all modalities (CT, MRI, radiology and ultrasound and obstetrics) for urgent requests, 27.7% were reported within 24 hours with 59.2% reported in more than 96 hours.
- There had been improvements in radiology reporting times for non-urgent outpatient requests from 55.4% reported in less than 24 hours in November 2015 to 86.2% in April 2016.
- Overall, in all modalities, for non-urgent outpatient reporting times, 39.6% were reported within 24 hours and 46.1% taking more than 96 hours with 14.4% reported in between 24 and 96 hours.

- Did Not Attend (DNA) rates remained an issue for the trust that had a target of 9.5% DNA rates. In adult clinics the DNA rate was 10% overall and in paediatric clinics the overall DNA rate was 16%.
- The trust had researched the reasons for the high DNA rates with a number of reasons being considered attributable. A high local area deprivation rate and a reliance on public transport, the location of the hospital often requiring several bus journeys; a lack of patient appointment choice for routine appointments and in paediatrics; a busy booking office, meaning that patients could not always get through to change appointments; short notice clinics being put on and no text reminders for paediatrics and over 65's were all reasons that were cited. In addition, a number of paediatric patients had not received appointment letters that were generally sent out by an outsourced company and this had increased the DNA rates.
- The trust were trialling a full booking service for paediatrics so that every parent or carer was spoken to and text reminder scripts were being reviewed. The call centre was staying open until 6pm two times per week and call centre staff had ring back lists so they could keep trying to contact patients to remind them of appointment times. They had planned to trial skype appointments for dermatology patients. In paediatric outpatients the trust was researching the Kings Fund model that had been trialled in a London trust. This was a patient-centred model where clinics could be held in the community with the assistance of GPs who were able to give useful information on family histories.
- We were assured that the trust were very proactive in seeking solutions to problems identified with DNA rates.

## Meeting people's individual needs

- The Language Interpretation and Patient Support (LIPS) Team was available 24 hours a day. Face-to-face services were available 9am to 5pm Monday to Friday and via telephone at all other times. The service offered language interpreting; British Sign Language to support people with hearing difficulties; translation services and cultural awareness training.
- The LIPS service had a clear set of aims that included: increasing the take up of services by ethnic minority groups; reducing the DNA rates amongst ethnic minority service users; reducing the number of recurrent GP visits



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due to communication difficulties; raising awareness of ethnic minority needs and providing information to users on accessing NHS services in their native language or in an easy read format.

- Leaflets on a number of conditions were available in different languages from the Health Information Centre and could be translated into other languages upon request. Languages available included Urdu; Punjabi; Cantonese and Polish.
- The volunteers ran a mobility scooter service for outpatients and visitors from the Hartshead South reception area. They were able to collect outpatients and visitors with reduced mobility from hospital carparks on a mobility scooter and transport them to wherever they needed to be in the hospital. Similarly, they would collect patients from their clinics and transport them back to the hospital exit or their vehicle. We observed that the service was busy and in constant use.
- All OPD and diagnostic Imaging services were wheelchair accessible.
- Bariatric beds were available to those patients who required them.
- Persons living with dementia and those with complex needs or learning disabilities were identified as far as possible in advance and medical records were marked accordingly. This allowed for their individual needs to be accounted for when outpatient appointments. For example, patients with learning disabilities were sent easy-read letters and could be located in a quiet area without distractions. Patients with complex needs could be allocated longer appointment times.
- There was a dementia specialist nurse working in outpatients and the trust aimed to have dementia link nurses in each outpatient area. We do not have a timeline on when they expected this to be in place. Patients living with dementia could bring a carer or relative with them for support and appointments were given at the start or end of a clinic to minimise waiting times and avoid the person becoming distressed. When drinks were offered to patients living with dementia we were told that staff ensured that they were served in suitable and safe cups. Local volunteers had knitted “twiddle muffs” that could be given to patients living with dementia to occupy their hands whilst waiting for their appointment.
- There were two disabled toilets in the main Hartshead South reception area. We observed that they were used

regularly but did open directly onto a main hospital thoroughfare and users did not always lock or even properly close the door so there was a risk to privacy and lack of dignity. A staff member on the Information Desk told us that this had been noticed and a request had been made for a prominent sliding “occupied” sign for the doors.

## Learning from complaints and concerns

- Complaints were handled in line with trust policy and were resolved locally wherever possible.
- Information posters on how to make a complaint were displayed in outpatient waiting areas.
- If PALS received a patient concern or complaint, they would contact the relevant manager who would try to resolve the complaint at the earliest opportunity, even before the patient had left the hospital. We were given an example of a patient who had attended the hospital that morning for an 8:30am appointment but the system showed that the appointment was at 9:30am. The manager apologised to the patient and told them that the matter would be investigated and they would be telephoned with an explanation. The patient was happy at the prompt action and did not want to take the matter further.
- Feedback from complaints was discussed at the weekly clinics planning meeting and was given to staff at meetings in the form of patient stories entitled “This happened last week. Let’s talk about it”. Staff were able to reflect on what had happened to a patient and how they could prevent future occurrences.
- Outpatients had only received one formal complaint in 2016/17 at the time of inspection.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated outpatients and diagnostic imaging services as good in the well-led domain. This is because:

- The trust had a clear vision and strategy for improving the outpatients and diagnostic imaging services that showed identified problems, proposed solutions, clear targets, future performance measurements and achievements to date.



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- The trust constantly monitored risks, performance and quality in outpatients and diagnostic imaging and could respond to bottlenecks in patient access and flow often before they had happened.
- Leadership was visible, supportive and communicated effectively with staff.
- Staff felt supported in their work and reported that there was an open and honest culture and they felt listened to.
- The public were engaged and enthusiastic to get involved to bring about service improvements.
- We saw a number of innovative practices to improve services and patient experiences.
- The trust sought potential solutions by researching with an outward vision by looking at what had worked well in other trusts, how any long-term improvements or solutions could be introduced with minimum disruption to patients and what results could be expected from introducing change.

## Vision and strategy for this service

- The trust had a clear vision and strategy for improving the outpatients and diagnostic Imaging Services and staff understood the improvement plan.
- The improvement plan showed a clear outline of the identified problems, a project structure and assurance and an assessment of the problems and an analysis of the probable causes.
- The vision and strategy had clear separate work streams for achieving outcomes with target dates and improvement measurements, for example, improvements to Friends and Family Test results, outpatient DNA rates and outpatient slot utilisation rates.
- The plan considered future measures, such as safety, infection prevention, patient experience and activity and efficiency and imposed clear targets.
- The strategy also included implemented actions to date, such as the introduction of a business and governance structure across the outpatient department; clinic start time audits; redesign of patient letters and leaflets and a redesigned performance dashboard.
- The effects of the changes were also included, such as, a reduction in outpatient DNA rates from 12% in June 2015 to 9.37% in May 2016 and a 15% increase in outpatient slot utilisation from April 2015 to May 2016.

## Governance, risk management and quality measurement

- RTT pathways and waiting times were monitored and improvements discussed at a weekly steering group that was chaired by the performance director. A quality and performance dashboard supported this. The group was alerted to any rise in diagnostic or outpatient waiting times and any bottlenecks building in clinical pathways. Strategies to address any issues were developed by the group, working with clinicians, within one week. The group was well embedded in the organisation. The group reported to a bi-monthly executive board meeting.
- The bi-monthly executive meeting ensured that every department designed a standard operating procedure and access policy
- The trust was represented at the National Data Quality Forum that met quarterly. Staff told us that this had proved useful for networking and for shared learning with other trusts.
- The trust carried out random audits on the accuracy of patient waiting times and processes to ensure that data quality reports for RTT were accurate.
- Two positive external audits had been carried out in relation to data quality and RTT waiting times. IMAS (NHS Interim Management and Support) had recommended that the trust could assist a failing peer trust in improving their waiting times.
- There was a clear reporting structure in place with consultants reporting to divisional meetings and ad hoc consultant meetings, as required. Divisional meeting groups reported to the operational board and service quality divisional governance group.
- The outpatients managers reported to the clinical director for surgery and there were monthly meetings that alternated between governance and business meetings.

## Leadership of service

- Staff reported that the trust chief executive and executive management team were visible and accessible and took the time to speak to staff.
- Staff were confident that the executive team knew what was going on throughout the trust and said that they instilled confidence to make decisions and improvements.

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- They reported that communication lines were good throughout the trust from “Board to ward” and back up and that there were no visible gaps in the chain of command.
- The trust had invested in senior clinical leadership, including the employment of a consultant sonographer who was one of only 12 in the country. A Band 8a radiology quality lead in diagnostic imaging supported them.
- Staff were confident that managers had the skills, knowledge and experience to carry out their duties and this was reflected in what we saw.
- We saw that managers encouraged supportive relationships among staff and had the capability to lead by example and effectively.
- We saw that leaders were consistently recognising concerns and problem areas and looking for ways to improve but were not offering knee-jerk reactions to concerns but were researching and offering longer-term solutions.
- Staff reported that they worked well as a team and that leaders were very supportive of them.

## Culture within the service

- Staff from receptionist to consultant level reported that there had been huge and positive changes in the trust in the last couple of years and that the trust was a good environment to work in.
- Staff who had worked in the trust for many years reported that they felt now felt included and supported and “part of a team” with a culture of openness and that they could discuss concerns up to chief executive level.
- Staff reported that there was a “no blame” culture and that bullying was not an issue.
- Staff said that they felt respected and valued and were not afraid to put forward improvements, no matter how small, for example, a cleaner had come up with the idea, and been encouraged to provide, “twiddle muffs” to patients living with dementia waiting in clinics.
- We witnessed that consideration was taken to maintain a patient-centred culture, considering the needs and experience of people who used the services. Staff were focused on giving patients a better experience and understood that this was the primary concern.
- We spoke to staff who said that the culture had turned around in the last few years and that they had pride in their work and were proud to work at the trust.

- A number of staff that we spoke to, who had only recently come to work at the trust, from larger trusts in Greater Manchester, had been encouraged to do so because of the culture and improvements that the trust had made and felt that they had made the right choice.

## Public engagement

- The trust were working with a local college with a view to offering an Assistant Practitioner Programme and offering work experience to young people under 18 to encourage them to train as nurses or take up other practitioner posts.
- The trust had set up a Patient Engagement Group to gauge feedback from patients before, during and after their outpatient appointments and drive improvements. The trust had carried out an outpatient survey and gauged interest for the group through this. One hundred and sixty one people had expressed an interest in being part of the Patient Engagement Group.

## Staff engagement

- There was a weekly email sent to staff from the chief executive called “Catch up with Karen” that kept staff informed of important news and developments.
- There was a monthly staff forum held with either the chief executive or medical director where staff could engage with the executive team. Staff told us that this was well attended.
- Team brief (important messages and trust news) was fed back to staff at team meetings on a monthly basis.
- Staff reported that they were and felt encouraged to make suggestions for improvements, that their suggestions were listened to positively and that the organisation was receptive to change.
- We were told that the central booking office restructure came about from suggestions made by staff in the service who could see how things could be done better to improve the service.
- The cleaning service been brought back into the trust, having been contracted out. Staff felt more included and part of the team, for example, they were invited to staff awards and parties.

## Innovation, improvement and sustainability

- We saw a number of innovative practices that had been put into place or were imminently to start operating such as: the virtual fracture clinic; being one of the first trusts in the North West to offer a Virtual Autopsy

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Service; offering a safe transportation service around the hospital via scooter, run by volunteers and working with local GPs to offer more patient centred clinics in the community where this was practicable.

- We saw evidence that, when a need to improve a service was identified, for example, in the fracture clinic, that they did not act with a knee-jerk reaction. Instead, potential solutions were researched with an outward vision by looking at what had worked well in other trusts, how any long-term improvements or solutions could be introduced with minimum disruption to patients and what results could be expected from introducing change.
- A strong service improvement team researched ideas for improving the quality of care and monitored the impact on quality, efficiencies and sustainability.
- Staff were encouraged to submit ideas for service improvements.

# Outstanding practice and areas for improvement

## Outstanding practice

- The radiology Department offered a “Virtopsy Service”. This virtual post-mortem service was used when a CT scan could determine the cause of death. This speeded up the process of determining cause of death and respected the religious and cultural needs of some of the local population. Scans were carried out at night and reporters were experts in reporting on virtual post-mortems. Deceased persons were transported to the unit via a private corridor. The trust were one of the first in the North West to offer this service.

## Areas for improvement

### Action the hospital MUST take to improve

#### Urgent care

- Ensure that patients can access emergency care in a timely way.
- Ensure all staff receive mandatory training at the required level and within the appropriate time frame.
- Ensure that fridges used to store medications are kept at the required temperatures and checks are completed on these fridges as per the trust's own policy.

#### Medical Services Including Older People

- Ensure there are appropriate numbers of nursing staff deployed to meet the needs of patients

#### Children and Young People

- Ensure all equipment used to provide care or treatment to a service user is properly maintained.
- Ensure that there is one nurse on duty on the children's ward trained and up to date in Advanced Paediatric Life Support on each shift.

### Action the hospital SHOULD take to improve

#### Urgent and emergency care

- Ensure that staff receive their annual appraisal.

#### Medical services including Older people

- Ensure children's safeguarding training across all professions within the medical directorate is up to date.
- Look to reduce the number of medical patients being cared for on surgical wards.
- Continue to monitor staffing arrangements on wards.

#### Surgical Services

- Take appropriate actions to improve mandatory training compliance rates.
- Take appropriate actions to reduce the number of cancelled elective operations.

#### Maternity and gynaecology

- Ensure the improvements in the infection prevention and control measures and the environment on ward 27 should continue.
- Emergency medicines should be safely stored in the obstetric theatre in line with trust's policy for the safe use of emergency medicines.
- Records should be securely stored in the ward areas.
- Appropriate actions should be taken to improve the mandatory training compliance rates for infection control and children's safeguarding.
- Ensure that a deteriorating patient's care was managed in line with the trust's policy.
- Continue to make improvements in the completion of the safer surgery checklists.
- Develop a system to ensure patients received required home visits by the community midwives.

#### Children and Young People

- Ensure recording of fridge checks include the maximum and minimum temperatures in accordance with national guidance.
- Ensure dates of cleaning and safety checks are legible on equipment.
- Review documentation for infants when intervention is reduced to high dependency or special care.
- Ensure the security and confidentiality of medical records in the paediatric outpatients department.

# Outstanding practice and areas for improvement

- Ensure PEWS documentation is completed and audited to improve compliance.
- Ensure the neonatal unit consistently collect patient feedback using the NHS Friends and Family Test.
- Ensure inpatient discharge summaries and outpatient clinic letters are sent in a timely way.
- Ensure regular staff meetings take place on the neonatal unit.

## End of life care

- Consider how it can increase uptake of the use of the individual care plan for end of life care patients.
- Consider how it can encourage improvement in the accuracy and completeness of DNACPR forms, including the undertaking and recording of mental capacity act assessments, the recording of best interests decisions, and discussions with patients and their relatives.
- Consider reviewing information held within the palliative rapid discharge link nurse files held in wards and units across the trust to ensure the information held is accurate, up to date, and in line with prescribing and dosage guidelines for anticipatory medicines.
- Consider what actions it could take to further increase the proportion of end of life care patients dying in their preferred place of care.
- Consider what actions it can take, within its control and where requested, to increase the percentage of end of life care patients discharged within the timescales of the rapid and fast discharge process.

## Outpatients and Diagnostics

- Continue the active recruitment of radiologists to meet actual WTE requirements and maintain safe staffing levels.
- Resolve the issue of allied health professionals being unable to accurately record mandatory training levels.
- Carry out an infection control risk review of positioning aids foam pads in radiology, to ensure that the risk of infection is minimised.
- Ensure that all entries on patient notes are signed and dated.
- Continue to increase the numbers of staff who have undertaken children's safeguarding training to meet trust targets.
- Review version controls on Local Rules for Radiation Protection and ensure that all staff have signed them to indicate that they have read and understood them.
- Continue to seek a solution to the lack of an electronic system that interfaces with local GP surgeries.
- Continue to seek viable solutions to reduce "Did Not Attend" (DNA) rates.
- Continue to seek solutions to improve "Referral to Treatment" (RTT) times so that all clinical pathways met national standards.
- Review the consultation room in clinic nine where the door opens outwards to improve privacy and dignity for patients.
- Review the children's play area in outpatients' clinics six to nine to see whether this could be better located or children observed and kept safer.
- Improve patient knowledge of how to access PALS should they need to do so.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not always provided in a safe way in that the risks to the health and safety of patients was not always assessed and mitigated.</p> <p>This is because patient flow throughout the hospital was an ongoing challenge, particularly in A&amp;E and medical care. 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. There were also long delays in A&amp;E.</p> <p>HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12, (2) (a) (b)</p>