

Salford Royal NHS Foundation Trust

# Salford Royal 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

Accident and emergency

Medical care

Surgery

Intensive/critical care

Maternity and family planning

Services for children & young people

End of life care

Outpatients

# Summary of findings

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# Summary of findings

## Overall summary

Salford Royal NHS Foundation Trust is an integrated provider of acute, community and primary care services with the majority of its services located at the Salford Royal Hospital site. It obtained foundation status on 1 August 2006.. It provides local services to the City of Salford and specialist services to Greater Manchester and beyond, treating about 400,000 patients every year. The trust provides a range of medical, surgical and emergency services, along with specialist care to people from across the UK who need expert help with brain, kidney, bone, intestine or skin conditions.

The trust is based at Salford Royal Hospital and serves one of the most deprived local authorities nationally (rated 26th out of 326 local authorities). The hospital has 676 beds for the population it serves.

Salford Royal NHS Foundation Trust has been inspected six times since its registration in April 2010. There are currently 15 active locations operating under this trust. The locations which have previously been inspected are:

Salford Royal Hospital: inspected three times. There are no outstanding actions.

The Maples: inspected once. There are no outstanding actions.

Heartly Green: inspected twice. There are no outstanding actions.

The trust was providing services at Salford Royal Hospital which were safe, effective, responsive, caring and well-led. This is an extremely well-run trust, with a strong and stable leadership team at executive and board level. We saw that strong, clear leadership in the trust was embedded at all levels within the trust, across all wards, consistently and without fail. Staff were encouraged to be innovative in improving the quality of care. They were able to tell us how quality was given a high priority and that patient care was personalised. For example, individual nurses are supported to make contact with relatives following a bereavement, to offer them further support.

The trust had effective structures and systems in place and showed an openness and commitment to continuous improvement. It put patient safety at the top of its priorities. Staff were focused on safety and what it meant in their own particular role.

The trust strives to be the best in the country and to deliver care which is safe, clean and personal every time (which they call SCAPE). All staff regardless of their role work to this ethos. Every member of staff we spoke to could tell us what this meant to them and all took pride in wanting to achieve the status for their ward or their area of work. The trust recognised the achievement of wards that had gained SCAPE status and the staff were rewarded with trust recognition for being a high performing ward. Information provided at the entrance to each ward informed patients and visitors how the ward was performing on being safe, clean and personal. This approach displayed an openness and transparency to visitors in how they were achieving this goal.

The vast majority of people we spoke with were very positive about the care and treatment they received at the hospital. Staff worked hard to involve patients in their own care.

The trust works hard to be transparent with staffing levels. Each ward we visited identified (at the entrance to the ward) the planned staffing numbers for each shift and the actual staffing levels provided. This clearly shows any patient or visitor if the ward is sufficiently staffed. Staff told us that they had regular updates on the numbers of staff and, if necessary, staff were moved to accommodate any shortages. The trust made use of bank and agency staff as appropriate. We did not identify any concerns about staffing levels.

Staff told us that they felt valued and respected in their roles. They were proud to work at Salford Royal and said it was important to them that patients had as good an experience as possible when they were in hospital.

The trust had a 'fair blame' culture which empowered staff to be fully involved in the way the trust was run. It encouraged all staff to learn from each other and share ideas. For example, we saw evidence of a housekeeper being fully involved in the quality improvement agenda

# Summary of findings

and identifying ways of improving the service and producing savings in the equipment budget. The trust was very proud to explain to us that this “fair blame” culture created a learning organisation which improved the quality of care.

The trust engages effectively with all external stakeholders and works to improve the quality of care provided to patients – both within the hospital and externally through its work with local GPs. We asked a range of stakeholders for their views before the

inspection. They all said this was a trust that delivered well. No one identified any concerns. The local clinical commissioning group said that the trust worked well with them and they provided “good value for money”.

The trust performed well on a number of indicators in the NHS staff survey related to patient care and support. They were better than expected for the proportion of staff who would recommend the trust as a place to work or receive treatment.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### **Are services safe?**

The trust's services were safe.

The values and behaviour of staff showed that the trust has an excellent culture of learning and openness. This is an important part of making sure patients are safe.

Qualified staff assessed patients' needs. There were processes for minimising risk to patients, for example falls risk assessments in Accident and Emergency (A&E). The trust has reduced the number of falls throughout its services and is significantly below the national target.

There was a comprehensive electronic patient records (EPR) system across all areas, except A&E, which is due to be included in the electronic system in January 2014. This allowed people to move through the hospital with accurate notes of their condition and treatment being available at all times.

The trust was open and transparent around staffing levels. We did not identify any concerns regarding staffing levels.

### **Are services effective?**

The trust's services were effective and patient focused. Outcomes for patients were good and there was a strong quality improvement programme that involved staff across the trust. Patients we spoke with said they felt well cared for and they had received the right treatment.

Staff we spoke to said they received good support from management, and in many instances they had autonomy in their job to make decisions which impacted positively on patients, such as increasing staffing numbers on wards if dependency or admissions increased.

### **Are services caring?**

The vast majority of people told us that they had positive experiences of care at the hospital. We saw a passionate, responsive and caring workforce that maintained dignity and privacy for patients throughout their journey through the hospital. The arrangements for caring for bereaved relatives and staff were exceptional. We found care was clearly based on patient needs and preferences. Staff responded to patients' needs in an appropriate and timely manner.

### **Are services responsive to people's needs?**

The services were very responsive to patients' needs. The trust consistently met all the targets in regards to waiting times and access to treatment such as cancer care.

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It handled all complaints appropriately and involved the person making the complaint, where possible. This showed the trust is interested in ensuring that people feel that their complaint has been addressed, listened to and resolved.

Staff had appropriate support so that they could respond effectively to patients' changing needs. The trust has numerous mechanisms in place to ensure that staff receive continuous training.

## Are services well-led?

The trust was extremely well-led with a strong leadership that focused on quality at all levels. This stable environment had been an important factor in enabling the trust to improve the quality of care for patients. There was good leadership at all levels, and this had had a positive impact on external partners, for example the local clinical commissioning group.

The trust understood risks within the hospital and demonstrated that it could respond appropriately. The trust showed us information on where it considered the risks to be and its plans to address the risks. This shows a trust which understands the pressures it faces internally and externally.

The trust sought to improve the quality of patient care by working internally and externally with local health partners such as GPs and with external stakeholders.

The trust leadership team were visible within the trust and work on the wards regularly.

# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

The A & E department provided safe, effective and well-led care. Staff were responsive to patients' needs.

We noted, at our initial inspection, that patients were not being offered refreshments when they had spent long periods of time in the department. This could have adversely affected the health of some patients. However, we found during the out-of-hours, unannounced inspection that this was not the case. Volunteers in the department offered patients refreshments.

Support was provided by consultants over a 24-hour, seven-day period, with consultants undertaking an "on call" rota between midnight and 8am. In addition, a resident consultant is available Friday, Saturday and Sunday between 11pm and 9am to cover trauma patients. More junior medical staff worked on a 24-hour rota system and were supported by a consultant. Middle grade vacancies were being covered by longstanding locums and active recruitment was being undertaken. There were sufficient nursing staff available to cover all areas in A & E and staff were fluid to move around as necessary.

The EAU department was staffed separately to A & E and sufficient medical and nursing staff were available.

### Medical care (including older people's care)

- Medical care services provided safe, effective and well-led care. Staff were responsive to patients' needs and there were systems in place to ensure that patients received the right care.
- Patients we spoke to said they felt to be well cared for. Staffing levels were seen to be appropriate, and staff were observed to provide care in a calm and unrushed manner. Staff were described as "kind".
- Staffing levels were sufficient.

### Surgery

- Surgery services provided safe, effective and well-led care.
- Staff were responsive to patients' needs.
- Three never events (events which should never happen) have occurred within the trust relating to surgical safety. The trust has looked critically at its practices and has set up the Theatre Safety Culture Collaborative. This will examine how the safety practice in theatre can be improved. The group is still in its infancy, and reports to the board.

### Intensive/critical care

- The critical care service provided safe, effective and well-led care.

# Summary of findings

- Staff were responsive to patients' needs. The units were calm and staff supported people who had questions about their own or their relative's care.
- The Critical Care service was situated in a purpose-built and fully equipped facility.
- There were sufficient numbers of suitably qualified staff to meet the needs of people in critical care and provide safe care.

## Services for children & young people

- Paediatric services provided safe and effective care. Staff were caring and the service responded to patient's needs.
- Patients (and relatives) we spoke to were complimentary about the care they received and how it was delivered. The service was well-led.
- Maternity services are not provided at the trust.

## End of life care

- The management of end of life care was well embedded across the trust. End of life care has clear clinical leadership and staff engagement.
- Staff were passionate about end of life care and the need to engage with individuals and their families.
- The trust had a clear strategy for responding to concerns regarding the Liverpool Care Pathway. It was committed to ensuring that end of life care was based on individual need and that all care was taken to ensure that people were fully involved in every part of the process.
- Robust mechanisms were in place for adhering to local and national standards for end of life care.
- We heard many examples of excellent practice in helping patients to die with dignity and in accordance with their wishes, in supporting family, friends and staff following a patient's death.

## Outpatients

- The outpatients department provided safe and effective care.
- Staff were caring and the service responded to patients' needs. Patients said staff treated them well.
- Patients said they received information about their treatment so they understood what was happening and that delays to appointment times were kept to a minimum. The service was well-led.



# Summary of findings

## What people who use the trust's services say

The Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment, showed an above average response from April 2013 to July 2013. In July, 90% of patients treated in accident and emergency said they would be extremely likely or likely to recommend the department to their family and friends.

In the 2012/13 Cancer Patient Experience Survey, the trust performed within the top 20% of one question: emotional support being given by hospital staff. Comments and reviews posted via Patient Opinion and NHS choices were

largely positive. Common themes included a good level of patient care and good communication with patients. CQC's Share Your Experience webform had nine comments, all of which were negative. Negative comments included time keeping, waiting times, inaccurate note taking, lack of privacy, and A&E not spending enough time assessing patients.

People we spoke to during the inspection (patients and visitors) were overwhelmingly positive about the care received.

## Areas for improvement

### Action the trust **COULD** take to improve

- There were some minor issues with the paper-based patient records system in A&E. However, these will be addressed with the adoption of the electronic patient records system in January 2014. The inspection team acknowledged that the paper-based system had no detrimental impact on patient care. After our announced visit, we were told that the trust had commissioned an independent report with demonstrated 100% compliance and provided assurance that its systems were safe and effective.
- Although policies and procedures were in place, in a small number of areas (A&E and children's care) some departmental policies were outdated. Up-to-date policies ensure that staff are aware of current procedural guidance within the trust. We raised this with the trust during our visit, and it addressed the issue immediately. This had not affected patient care.

## Good practice

Our inspection team highlighted the following areas of good practice:

Our inspection team highlighted the following areas of good practice:

The Bereavement Centre (also known as the Pam Wood Suite) provided a service to bereaved families and friends efficiently and with great sensitivity. The staff at the bereavement centre also provided a service to staff who may be affected by death. The praise given to this centre on our visit was exceptional. Everybody we spoke to felt that this service was outstanding, as it supported the whole hospital and the attitude and compassion shown by the staff were exceptional.

The EPR (electronic patient records) system was extremely well used in all areas (apart from A&E) and provided for a largely paperless organisation. Staff at all levels appreciated this, and it meant that a patient could move seamlessly through the organisation and their medical history was easily available wherever they went.

The trust demonstrated exceptional leadership qualities at all levels across the staff groups. The engagement and leadership of the non-executive directors and the governing council were outstanding. This supported a learning culture where everyone was encouraged and able to contribute. The trust said it was proud to enable a learning culture rather than a blame culture. It felt this allowed staff to be responsible for their own errors and to learn from them.

# Summary of findings

The trust strives to be the best hospital in the country and has worked hard to embed this among every member of staff. It has key values of 'Safe, Clean, Personal' which were demonstrated at all levels and throughout everything it does, and were clearly meaningful to all staff. This message was evident in practice in wards known as SCAPE wards. (Safe, Clean and Personal Every Time). Every member of staff we spoke to could describe to us what SCAPE meant to them and how it improved the quality of the experience for the patient. Every member of staff wanted to be associated with a ward that had achieved SCAPE status. The award of SCAPE status was highly valued by all staff. It was clear recognition of a high quality and high performing ward which put safety, cleanliness and personalisation for patients at the top of its priorities. The award could be taken away if the quality was not maintained. This meant staff wanted to continually achieve and keep this status for the benefit of patients.

The trust had systems on its wards for being totally transparent about staffing levels. Patients, visitors and other staff therefore could see quite clearly if staffing levels were being maintained.

As part of the quality improvement agenda, the trust has set up a junior doctor support group called Trainees Improving Care through Leadership and Education (TICKLE). This enabled trainee doctors doing part of their training at the trust to contribute effectively to patient safety and quality improvement work. This level of engagement with junior doctors was excellent and commented on positively by junior doctors in the focus groups held.

Safety 'huddles' were a routine part of handover practice across the trust and allowed efficient transfer of information between shifts and outside of normal shift handover. These took place twice daily to ensure that everyone had up-to-date information.

A&E had recently created the post of transfer co-ordinator to help move patients from the department, once a bed was available in the hospital. This post was proving to be successful in ensuring that patients received a smooth transfer between departments.

Over the previous 12 months, the trust had significantly reduced the incidence of patients having surgery cancelled on the day by having an effective pre-assessment process.

The trust had significantly reduced the number of falls on the frail elderly ward by providing one-to-one care for patients at risk. The number of falls was below the national average. This is a remarkable achievement.

The trust provided systems for all patients, relatives and staff to be aware of the planned staffing level and the actual staffing level for each ward. This showed an openness and transparency from the trust, and a willingness to be challenged around sufficient staffing provisions.

The trust worked well with external stakeholders such as GPs to improve the quality of the healthcare within the hospital. For example, staff at the trust could book appointments with local GPs for patients. This was part of a "deflection" programme set up with the local GPs to try and reduce waiting times in A&E and provide an improved service to patients if their local GP was better suited to treating their condition. In addition, patients who left A&E before being seen were contacted by hospital staff to see if they still needed assistance, and advice was offered as necessary.

# Salford Royal Hospital

## Detailed findings

### Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Children's care; End of life care; Outpatients

## Our inspection team

### Our inspection team was led by:

**Chair:** Dr Kathy McLean, Medical Director NHS Trust Development Authority

**Team Leader:** Tracey Devine, Care Quality Commission

The inspection team comprised CQC inspectors, doctors, nurses, senior managers, inspectors, lay people and Experts by Experience. Experts by Experience have personal experience of using or caring for someone who uses the types of services we were inspecting.

The doctors on the team included two executive medical directors, two doctors and one trainee doctor. The nursing staff included an executive nurse, two matrons, a nurse and a student nurse. In addition, there were a chief executive and a senior manager on the team. There were three public and patient representatives in the team.

## Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are testing the new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England, according to our new 'Intelligent Monitoring' tool. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations.

Under this model Salford Royal NHS Foundation Trust was considered to be a low risk service.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?

# Detailed findings

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

The inspection team always inspects the following core services at each inspection.

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Maternity and family planning are not provided at this hospital and were not therefore included.

The lines of enquiry for this inspection were informed by our Intelligent Monitoring data.

As part of the inspection process we contacted a number of key stakeholders and reviewed the information they gave to us. We also reviewed information we hold about the service. We received information from organisations including Healthwatch, the medical Royal Colleges, Monitor, Salford Clinical Commissioning Group and Health Education England.

We carried out an announced inspection visit on 23 and 24 October 2013. As part of the inspection, we looked at the personal care and/or treatment records of people who use the service, and we observed how staff cared for patients and talked with people who use services. We talked with carers and family members. We held focus groups with:

- Clinical directors
- Consultants

- Doctors
- Junior doctors
- Nurses
- Junior nurses
- Support workers and student nurses
- Allied health professionals
- Catering/domestic/porters
- Non-executive directors and governors
- Administrative staff
- Patients

We had daily drop-in sessions for people who wanted to tell us what they think about the trust's services. The drop-in sessions were open for staff or patients who wished to talk to us on a more one-to-one basis. We placed comment boxes around the hospital site and received four comments from people who used the service.

We interviewed a range of staff including the Chair, the Chief Executive, the Medical Director, the Nursing Director, the Director for Salford Healthcare Division, the Associate Director of Governance and Quality, the Assistant Director for Quality Improvement and the Complaints Manager. We also met with the trust governors and two non-executive governors.

We attended a community group known as Binoh on 16 October 2013. This group represented Jewish people who use the service.

We held a public listening event on 23 October 2013 at Swinton Park Golf Club, for people to tell us their experience of the trust.

We carried out an unannounced inspection of the trust on 29 October 2013. We looked at the personal care and treatment records of patients, observed how people were being cared for and talked with staff and patients.

# Are services safe?

## Summary of findings

The trust's services were safe.

The values and behaviour of staff showed that the trust has an excellent culture of learning and openness. This is an important part of making sure patients are safe.

Qualified staff assessed patients' needs. There were processes for minimising risk to patients, for example falls risk assessments in Accident and Emergency (A&E). The trust has reduced the number of falls throughout its services and is significantly below the national target.

There was a comprehensive electronic patient records (EPR) system across all areas, except A&E, which is due to be included in the electronic system in January 2014. This allowed people to move through the hospital with accurate notes of their condition and treatment being available at all times.

The trust was open and transparent around staffing levels. We did not identify any concerns regarding staffing levels.

The data we were given before our inspection included figures for infection rates for *Clostridium difficile* and MRSA bacterial infections from July 2012 to June 2013. They were within a statistically acceptable range for a trust of this size.

The trust had a falls dashboard, which it used to monitor the number of falls and slips in each ward every day. There was an escalation process for reviewing any falls that had resulted in harm. This showed that systems were in place to provide appropriate care to patients at risk of falling.

Staff were suitably trained to care for patients' specific needs, and they provided care in safe and caring environments. Patients' needs had been assessed and risk assessments had been carried out to help staff provide care that was appropriate to patients' needs. Staffing levels were sufficient in all areas.

The environment was clean. In all areas, we saw cleanliness stickers telling people that equipment had been cleaned and was ready for the next patient. One patient told us, "The place is really clean now. It never used to be, but now it's spotless." There are clear messages at the entrance of each ward asking everyone to wash their hands on entry and exit.

The trust was within the national average for slips, trips and falls (0.51% against a national average of 0.87% in August 2013). The wards were tidy and free from hazard. We saw patients with mobility problems asking for help and staff helping them promptly. The trust has below the England average for falls with harm. The trust introduced a falls change package which has been successful in significantly reducing the number of falls within the trust.

At August 2013, the trust was also within the national average for pressure ulcers, recording a score of 0.94% against a national average of 1.09%. The trust set itself a target of no grade 3 or 4 pressure ulcers to be acquired in the hospital – this target has been achieved and maintained for more than 12 months.

We saw a copy of the critical care passport, which recorded information about a patient's personal needs and was used in all the critical care areas. It included information on dietary preferences, religious/spiritual needs, sleep patterns and any communication issues. The information was used to ensure that care was personal and comfortable.

## Our findings

Before our inspection visit, we reviewed a number of factors relating to patient safety at the hospital. These included rates of avoidable infections, reporting of incidents, the occurrence of three 'never events' (errors in care that should never happen) and reported deaths for people with low-risk conditions or procedures.

We found that the rates for each of these were within expected limits against national data. This indicated that the care provided at Salford Royal Hospital was safe.

During our inspection we looked at services provided in accident and emergency (A&E), medical care, surgery, intensive/critical care, paediatrics/children's care, end of life care and outpatients. We found them to be safe for people using those services.

There were appropriate processes for protecting patients from abuse. Staff had a good understanding of their role and responsibilities with regard to protecting adults and children.

## Are services safe?

Staff used a safety huddle each morning to hand over safety information about patients and update staff on patients' clinical status. Staff on all units had regular update meetings to ensure everyone was aware of changes in individual patients' needs.

All areas carried out 'intentional rounding'. This process ensures that staff review each patient's condition at hourly intervals. This ensures timely and effective management of any changes in the patient's condition.

The trust monitored and reviewed departmental risks through monthly clinical governance meetings.

The palliative care team had a weekly meeting to review every new referral to the team. Any information from this meeting was entered into the electronic record 'Co-ordinate my care', which ensured that all relevant communication and identified needs were fully recorded. This ensured staff were fully up to date with the needs of the patients in their care.

Patients received effective, safe and appropriate care. Treatment reflected their needs, preferences and diversity. Qualified staff carried out the analysis of diagnostic tests and assessments. There was a sufficient number trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.

The trust had good reporting mechanisms into a variety of national audits, for example cancer care audits.

The trust uses the Department of Health Safety Thermometer (which measures patients safety), and it uses results to inform improvements in care. The Safety Thermometer data shows that 92% of patients receive harm-free care.

Appropriate equipment was available in the hospital, and staff managed it adequately. This meant patients were protected against the risks of unsafe or inadequate supply of equipment.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

The trust's services were effective and patient focused. Outcomes for patients were good and there was a strong quality improvement programme that involved staff across the trust. Patients we spoke with said they felt well cared for and they had received the right treatment.

Staff we spoke to said they received good support from management, and in many instances they had autonomy in their job to make decisions which impacted positively on patients, such as increasing staffing numbers on wards if dependency or admissions increased.

## Our findings

Before our inspection visit, we reviewed data relating to the effectiveness of the care provided at Salford Royal Hospital.

This included respiratory conditions and care, stroke care, cardiac conditions, elderly care and the paediatric pathway. The data showed that the care provided at Salford was effective in the areas reviewed.

The Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment, showed an above average response from April 2013 to July 2013. In July, 90% of patients treated in Accident and Emergency said they would be extremely likely or likely to recommend the department to their family and friends.

We found that the hospital was providing effective and consistent care across all services at all times of the day. The trust is patient focused and works effectively to improve the quality of the care delivered.

We also examined mortality data. We found that the trust mortality rates, across a range of measures, were similar to or much better than expected for most of the areas. We also found that the care provided at weekends was consistent with the level of care provided during the week in terms of mortality.

The trust had clear governance structures for assuring good quality and effective treatment and care.

# Are services caring?

## Summary of findings

The vast majority of people told us that they had positive experiences of care at the hospital. We saw a passionate, responsive and caring workforce that maintained dignity and privacy for patients throughout their journey through the hospital. The arrangements for caring for bereaved relatives and staff were exceptional. We found care was clearly based on patient needs and preferences. Staff responded to patients' needs in an appropriate and timely manner.

## Our findings

Staff treated patients and their families with dignity and respect. The vast majority of people said that they felt involved in their care and that staff kept them informed.

We left comment cards around the hospital on both days of our inspection. Of the four comments cards we received as

part of the inspection, three gave positive comments about the care at the hospital. One person commented, "I have been treated with great care and dignified respect from the desk staff to the specialist." One person actively sought out the inspection team to provide information on the high quality of service their relative and themselves had received, not only in terms of nursing care but also emotional care.

We also received information via our website. Most of the feedback was very positive. Some of the comments related to the use of agency and bank staff. We explored this during our inspection and did not identify any concerns with the management of staff or cover for sickness.

Staff told us they were proud to work at Salford Royal and said it was important to them that patients had as good an experience as possible when they were in hospital.

The trust actively seeks patient feedback through a number of methods including surveys, patient stories and patient experience trackers, all of which provide information on how to improve care.



# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

The services were very responsive to patients' needs. The trust consistently met all the targets in regards to waiting times and access to treatment such as cancer care.

It handled all complaints appropriately and involved the person making the complaint, where possible. This showed the trust is interested in ensuring that people feel that their complaint has been addressed, listened to and resolved.

Staff had appropriate support so that they could respond effectively to patients' changing needs. The trust has numerous mechanisms in place to ensure that staff receive continuous training.

open approach to dealing with complaints, and it included the person making the complaint where possible. This ensures that people feel that their complaint has been addressed, listened to and resolved.

The trust was achieving the 95% national target for the percentage of patients admitted or discharged within four hours of arriving at Accident and Emergency (A&E). Most weeks, the trust was exceeding the national target.

The trust had volunteers in A&E and the outpatients department. Part of the volunteer duties in A & E were to assist with ensuring that vulnerable patients were offered a drink while waiting in the department.

During our unannounced visit we observed handover procedures from the day staff to the hospital at night team and the handover of junior doctors to their night colleagues. These handovers were effective and well managed.

The hospital had a chapel and a prayer room to meet the needs of people with religious beliefs. Hearing loops were available for people who had impaired hearing. Patients had a choice of food and there was a 'multi faith' menu available to cater for people's individual dietary requirements. This meant staff responded to patients' needs.

## Our findings

The trust responded to people's needs. Most patients had their needs met in a timely manner. When people raised complaints and concerns, these were responded to appropriately. Staff made changes to patient care as a result of feedback. Complaints were viewed as a positive mechanism to improve service delivery. The trust had an

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

## Summary of findings

The trust was extremely well-led with a strong leadership that focused on quality at all levels. This stable environment had been an important factor in enabling the trust to improve the quality of care for patients. There was good leadership at all levels, and this had had a positive impact on external partners, for example the local clinical commissioning group.

The trust understood risks within the hospital and demonstrated that it could respond appropriately. The trust showed us information on where it considered the risks to be and its plans to address the risks. This shows a trust which understands the pressures it faces internally and externally.

The trust sought to improve the quality of patient care by working internally and externally with local health partners such as GPs and with external stakeholders.

The trust leadership team were visible within the trust and “walked the wards” regularly.

There were clear reporting structures in place. The trust Board had a good understanding of the key issues affecting the trust and a willingness to address issues identified.

The Board had remained stable over the past few years. The Chair had been in post since 2008 and the Chief Executive had been in post since 2001. Supported by the Board, the senior executive team has provided a clear vision, which has been embedded over the years throughout the hospital to continuously improve services and patient care.

Senior staff were empowered to share good practice and encourage more junior staff to be fully involved in all areas of the trust.

There was a clear organisational structure in place. There was also a clear governance and risk management structure, and all of the staff we spoke to were aware of the risk register. The trust had introduced a junior doctors’ support development/support group called Trainees Improving Care through Leadership and Education (TICKLE). This was started to enable junior doctors carrying out part of the training at Salford Royal NHS Foundation Trust to contribute effectively to patient safety and quality improvement work. It had increased the trust’s engagement with the junior doctors and strengthens the relationship between them. The junior doctors we spoke to said they felt valued and that this type of group was not one they found in other trusts they had worked in. This was felt to be innovative to this trust.

## Our findings

The trust was extremely well-led. The leadership team offered stability and a clear vision on providing a high quality hospital to the community of Salford.

# Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Information about the service

The Accident and Emergency (A&E) Department provides 24-hour care, seven days a week, for all accidents and emergencies. It is also a Major Trauma Centre for approximately 85,000 patients throughout the year. The service has a minor treatment area which consists of 15 bays, a major treatment area with 12 bays and a resuscitation area for emergency care with 8 bays, which include 1 bay specifically for paediatric patients. The department is led by a clinical director, lead nurse and a matron.

All areas were staffed by individual teams but the teams were available to cover other areas when needed.

We visited the A & E department and the Emergency Admissions Unit (EAU).

## Summary of findings

The A & E department provided safe, effective and well-led care. Staff were responsive to patients' needs.

We noted, at our initial inspection, that patients were not being offered refreshments when they had spent long periods of time in the department. This could have adversely affected the health of some patients. However, we found during the out-of-hours, unannounced inspection that this was not the case. Volunteers in the department offered patients refreshments.

Support was provided by consultants over a 24-hour, seven-day period, with consultants undertaking an "on call" rota between midnight and 8am. More junior medical staff worked on a 24-hour rota system and were supported by a consultant. Middle grade vacancies were being covered by longstanding locums and active recruitment was being undertaken. There were sufficient nursing staff available to cover all areas in A & E and staff were fluid to move around as necessary.

The EAU department was staffed separately to A & E and sufficient medical and nursing staff were available.

# Accident and emergency

## Are accident and emergency services safe?

Patients in A&E were cared for in a safe environment. Patients arriving in the department were seen by a nurse promptly and triaged according to their need. Any urgent patients were transferred quickly to be seen by a doctor.

Sufficient consultants, medical and nursing staff were employed. Consultants were available from 8am till midnight, seven days a week, with “on call” arrangements in place between midnight and 8am. In addition, a resident consultant is available Friday, Saturday and Sunday between 11pm and 9am to cover trauma patients. Junior doctors said they always had access to a consultant. Some middle grade vacancies were in the process of being recruited to. Suitable cover arrangements were in place.

One patient told us, “I was very poorly this morning, I was brought here by the ambulance and now I feel safe. It’s a big thing to feel safe when you’re poorly. I feel I can overcome anything as the staff are so kind. I am very lucky to have been brought here.” Patients we spoke to in A&E said they felt safe. We saw staff attending to patients appropriately.

The A&E department currently used paper based records to record contact with patients. However, this was not in line with the rest of the trust, which used electronic patient records. There were plans for A&E to start using the electronic records system in January 2014. The use of paper records did not impact on the care delivered.

Staff consulted with colleagues at regular intervals both to check their actions and to clarify needs and actions. We saw that this helped staff to provide the most appropriate care to patients within recommended guidelines. We saw junior staff having conversations with more senior staff to review treatment plans at regular intervals. This showed all grades of staff were valued for their contribution.

Services were efficient and effective. Patients were transferred to an appropriate setting to receive care applicable to their need. They were seen by an appropriately qualified member of the clinical team.

The department had adapted the trust-wide electronic record for assessing the risk of falls to reflect the specific

needs of patients attending A&E. This was in paper format and used for all A&E patients. This ensured staff could take appropriate action to minimise the risk of falls to the patients within the department.

Staff had received appropriate training to allow them to carry out their roles. Training was ongoing, and there was a robust monitoring system for ensuring that staff complete relevant training within an appropriate timeframe.

A&E staff took part in a ‘safety huddle’ (handover) twice a day to discuss particular pressures on the department and to ensure all staff were aware of patients within the department and their specific care needs. This ensured that staff were fully up to date with the needs of every patient in their care.

The department also carried out ‘intentional rounding’. This involves staff reviewing each patient at set intervals. A systematic approach to intentional rounding can improve the patient’s experience of care and increase their trust. It can also ensure that care is safe and reliable. We saw that this was well established practice.

Although policies and procedures were in place, not all A&E policies were up to date. However, we saw no evidence that this was impacting on patient safety. Regardless, the department does need to update its current policies and procedures and ensure that all staff are familiar with them. This is particularly important considering the department uses bank staff (staff who agree to fill gaps in a rota) and agency staff.

There was sufficient equipment for emergency care of patients, and all staff had received training on how to use the equipment. All equipment was checked daily and was replenished and rechecked after use.

There were appropriate processes in place for safeguarding patients (protecting them from abuse). Staff we spoke to had a good understanding of their role and responsibilities with regard to safeguarding adults and children.

A&E had a close working relationship with all areas of the trust. Now that it has appointed a transfer co-ordinator to help move patients from A&E to a bed in the hospital, it aims to strengthen this relationship. As a result of this, there will be a more timely movement of patients into beds in ward areas.

# Accident and emergency

## Emergency Assessment Unit

We visited the Emergency Assessment Unit (EAU) which is attached to the A&E department and is the first ward patients will usually be admitted to from A&E. The unit was clean and well maintained, and it had a total of 55 beds and a patient waiting area for patients awaiting test results that had been taken in A&E.

The department adhered to single sex accommodation regulations, and male and female bays and bathrooms were clearly identified.

A whistle blower had contacted us during the inspection and raised some information of concern regarding EAU. We looked at the issue in question during our unannounced inspection and discussed it with the trust. We found that the trust was aware of the concerns and was in the process of dealing with the information in an appropriate and timely manner. The trust agreed to inform us of their continued action in respect of the concerns raised.

We found EAU to be a safe and secure department that only had one patient exit route, which was observed by reception staff at all times. This assured us that patients with dementia and confusion who could be admitted to the area from A&E would remain safe, as they would not be able to leave the department unnoticed.

### Are accident and emergency services effective?

(for example, treatment is effective)

The department was recently refurbished and was well maintained and stocked with the required equipment for the department to carry out its functions effectively.

The delivery of care and treatment was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence.

Records showed that the department followed specific care pathways to ensure the patients received care appropriate to their needs. Staff showed us pathways for 'fractured neck of femur' patients that followed best practice guidelines for surgery within 36 hours from A&E or from time of diagnosis if an inpatient. These pathways were based on Standard 1 from the Management of Hip Fracture Care of the Best Practice Tariff standards. This ensured patients received the right care, promptly and in the right place.

The Clinical Quality Indicators in September 2013 showed that A&E was achieving the national target of seeing 95% of all patients within four hours of attendance at A&E.

However, during September 2013 it did not achieve the four-hour guideline for patients who required admission. Patients were triaged against health priority, not against time of arrival in the department. Staff are able to offer and book appointments for people with their local GP if they present at A&E and it is considered more appropriate for them to see their GP. This ensures that people are not waiting for treatment which could be better obtained locally and that A&E is used to its full extent. This ensures that people who need treatment are offered appropriate advice.

The minor injuries services' opening times were from 7am until 12 midnight. They were staffed by an emergency nurse practitioner, which allowed more serious cases to be seen by the consultant and other medical staff.

Ambulance crews informed us that the ambulance waits were well within the recommended guidelines and they felt that the trust had reduced its wait times in recent months by having a dedicated ambulance triage person available in the major area of the department.

Between April 2013 and July 2013, the department had an above average result for the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. In July, 90% of patients treated in A&E said they would be extremely likely or likely to recommend the department to their family and friends.

National data showed that the hospital was achieving 98.2% of ambulance handovers to A&E staff within the acceptable target.

### Are accident and emergency services caring?

We saw staff treating patients and relatives with dignity and respect. Staff maintained privacy by ensuring all doors were closed, where appropriate. We found all doors were securely closed when a patient was receiving care and during consultations.

We only received positive comments about the service, and all patients were complimentary about staff.

# Accident and emergency

Patients received relevant information leaflets on discharge to ensure that ongoing care could be effective.

The A&E department had an excellent bereavement support process that a link nurse had helped to design. The team offered emotional and practical care to families who had lost a loved one.

The service included a follow-up phone call to the family the day after a death to ask if they had any further questions.

Staff treated patients in EAU with dignity and respect. Where possible, they fully involved patients in their care plans and kept them up to date with their test results and assessments of their care needs. Where it was not possible to communicate effectively with patients, relatives were kept fully informed either in person or by phone.

Patients told us, “We have been well looked after, the doctors and nurses are really caring and explain things so we can understand them. We have been kept fully informed” and “My only complaint would be we have not been offered a cup of tea, and when I asked we were advised to go to the shop and bring one in.” In contrast to the latter comment, one person told us that they had asked the receptionist for refreshment, and she had made them a drink straight away. Another person told us, “I was seen immediately on arriving in the ambulance I felt really special and they have been so kind to me. They contacted my daughter for me.”

A relative in EAU told us, “My relative has been given exceptional care up to now. We have as a family been well looked after and staff have explained fully the care we should expect in a language we can understand. The doctor has been wonderful in A&E. My relative tends to wander about and staff have shown us the measures available within the ward to keep her safe, and we are very reassured.”

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

There was a robust process in place to monitor and review complaints. Patient feedback and patient stories are shared with the Board to allow learning to take place to address any themes which may be arising.

We were told the department included patients and their relatives in the investigations of all incidents and complaints. This allowed the trust to demonstrate its transparency and willingness to share information, and it allowed families to be confident the incidents were fully investigated.

Staff told us that the department used the ‘5 WHY’ method of analysing the causes of incidents and accidents. This method involves asking a series ‘why?’ questions to explore the cause and effect relationships behind a problem. Investigations started in the department but was overseen by managers from other areas. This allowed sharing of information and experience across departments. All incidents were discussed at staff meetings and learning was recorded to enable staff to reflect on incidents and learn from them.

During the initial inspection we did not see anybody offering patients refreshments when they had been in the department for long periods of time. However, on the unannounced inspection we found that there were volunteers who worked within the department and part of their role was to ensure patients were adequately hydrated and fed during their stay.

The patient pantry was adequately stocked to cater for special diets and for the cultural requirements of patients within the department. We were told that once patients have been seen by the doctor, if the doctor gave consent the patient was offered appropriate refreshment.

We saw the department’s major incident plan for handling unforeseen major incidents and reviewed the facilities it had available to accommodate this. We were told the plan had not been instigated in the past year, but the last time it had been used the trust had evaluated it fully and made changes as required.

The Clinical Quality Indicators for September 2013 showed that 2.8% of attending patients had left the department before seeing any medical staff. A senior doctor reviewed the records of these patients and the patients’ GP was informed, where necessary. The lead nurse explained that for those patients who regularly attend and leave without treatment, the department called them the day after their visit to see if they still needed to be seen.



# Accident and emergency

The department had close working relationships with the Mental Health Team. There was a room set aside where patients with a mental health need could wait until the team could see them.

The department had recently piloted a transfer co-ordinator role, which was undertaken by a health care support worker. They took responsibility for the journey of patients through the department when they were admitted to the hospital. They were responsible for liaising with the ward most relevant to support the ongoing care of the patient and to finalise the bed and then ensure timely movement of the patient. The evaluation of the pilot had gone positively, and the role had been advertised as a permanent position.

## Are accident and emergency services well-led?

We found A&E was well-led by the senior team within the department. We saw senior doctors and nursing staff sharing information and advising junior staff on the actions they proposed for patients' ongoing care.

We saw there was a strong team spirit in the department. Staff covered each other and communicated well with each other to ensure everyone was aware of any changes.

We looked at staffing levels and discussed them with the lead nurse. They informed us that there had been recent changes to some duty rotas for emergency nurse practitioners to allow them to fulfil their job roles. Advanced nurse practitioners who had been supported to develop advanced skills were now working alongside the junior doctor team, delivering care in a supportive manner.

Staff were very proud to work in the department and were passionate about the work they carried out.

Staff we spoke with told us that senior staff were highly visible within the department at all times, and they were part of the 'safety huddle'. Staff felt supported in their roles and told us they felt able to ask for support as and when required.

Staff told us they received appropriate training for their roles and they updated their skills on an annual basis.

The department had embedded the trust's change agenda. We were told that they were constantly evaluating their roles and making changes to try to make the patient journey through the department easier.

There were appropriate clinical governance arrangements in place to report and manage risk.

A&E staff took turns to work in the paediatric emergency area to maintain skills and learn new ones. This allowed the staff to work flexibly, if needed, to cover sickness or absence. The department constantly monitored staffing levels, and staff placed in those areas needing support. Staff appeared willing to help out in other areas.

When there was an emergency admission, we saw staff prioritising workloads to allow sufficient support for the emergency team. Once the situation was under control, staff returned to their areas and we saw staff explaining to patients why there had been a delay in their care. Communication was clear, and it did not disclose any confidential information.

Doctors told us they felt very supported and could always ask for help – either from the senior nursing staff or the medical team. The A&E consultant explained to us the staffing levels for medical staff, which demonstrated that support was available at all times for junior staff within the department.

There was effective teamwork in the department, and staff were considerate of each other's needs. There was effective communication between all grades of staff.

Appropriate clinical governance arrangements were in place to monitor patient safety. There was appropriate leadership for all grades of staff.

# Medical care (including older people's care)

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The Acute Care of the Elderly service is managed across seven wards by four consultant geriatricians. The service has a variety of interests, including falls, orthogeriatric liaison, Parkinson's disease and epilepsy in older adults. Acute Medical Services include renal, gastroenterology, respiratory and stroke services.

We visited all the wards providing acute medical care.

## Summary of findings

Medical care services provided safe, effective and well-led care. Staff were responsive to patients' needs and there were systems in place to ensure that patients received the right care.

Patients we spoke to said they felt to be well cared for. Staffing levels were seen to be appropriate, and staff were observed to provide care in a calm and unrushed manner. Staff were described as "kind".

Staffing levels were sufficient.



# Medical care (including older people's care)

## Are medical care services safe?

Staff assessed patients' needs and planned care to meet those needs, including care after discharge from hospital. Sufficient staffing levels were maintained on wards.

On the wards, staff used a system called 'intentional rounding', which involved making hourly checks to ensure that patients were safe and receiving the right care and support. On some wards patients for patients who received one to one care the intentional rounding was every hour.

This was particularly evident on the frail elderly and renal wards and meant that staff monitored patients who were at risk of falling, to ensure their safety.

To ensure that people living with dementia received appropriate care and support, services used the dementia and delirium strategy and dementia assessment. This helped staff give an appropriate response to the needs of patients living with dementia. These practices helped medical and nursing staff to decide if patients needed one-to-one care.

When patients were admitted via A&E to the gastrology wards with alcohol related needs, as part of the dementia and delirium strategy they were placed on an alcohol detoxification pathway and prescribed medication. Staff monitored them hourly and altered their medication to reduce their distress, if necessary.

The records of assessments and clinical decisions made for three patients who lacked capacity did not demonstrate that the patient or their family had been included in the decision regarding the need for one-to-one care. For example, one family told us that staff had not consulted them about the need for one-to-one care for their relative. When they visited, they found a male carer supporting their female relative, which did not meet their cultural preferences. This was raised with the ward manager for their attention. Other records we looked at supported capacity assessments had been made.

To minimise the risk of falls, staff had completed appropriate risk assessments. Where necessary, services employed extra staff to provide adequate supervision to patients at high risk of falls. The trust used a 'falls dashboard' to monitor the number of falls and slips in each

ward every day. There was an escalation process for reviewing any falls that had resulted in harm. This showed that effective systems were in place to provide appropriate care to patients at risk of falling.

Staff followed the trust's policies and procedures for infection prevention and control. Patients who had an infection and presented a risk to others were 'barrier nursed' (given treatment in isolation) in side rooms and an orange symbol indicated they were a risk of infection. Staff told us that they discussed infection prevention and control every day in the midshift handover called the 'safety huddle'. There are very clear yellow visible signs at the entrance to each ward asking everyone to wash their hands on entry and on leaving the ward. The signs could not be more clear. However, we saw some instances when patients, staff and visitors did not wash their hands when entering or leaving the ward areas. We did not see anybody challenge this group of people although all staff we spoke to said they would challenge people if they saw that hands had not been washed.

Staff assessed patients at the point of admission to find out if they were at risk of developing pressure ulcers, and they completed care plans for those who were at risk. There were tissue viability nurse specialists who supported wards and monitored and reported on pressure ulcers throughout the hospital. Staff told us that pressure-relieving equipment was available when needed.

For the majority of the time period between August 2012 and August 2013 the trust had a new pressure ulcer rate below the national average. It reported fewer new pressure ulcers among the over 70s patient group for the majority of the period between August 2012 and August 2013. Between August 2012 and September 2012, and December 2012 and January 2013, the trust was above the England average. The trust prides itself on the fact that no pressure sores above grade 3 and 4 have occurred in the last 12 months. This is a target it continues to set itself and to which all nursing staff are aware of. Information regarding pressure sores is clearly visible on entry to each ward. This ensured that the patients and their families/visitors were aware of the trust's ambition alongside nursing and auxiliary staff.

Services displayed staffing levels on a staffing board at the entrance to each ward. This indicated the expected and the

# Medical care (including older people's care)

actual staffing levels for registered nurses and care support workers on each ward during each shift. Patients said that staffing levels on the wards were good and we saw that staff were responsive to patient's needs.

Two visitors on one ward told us they were visiting a family friend for the first time, and one of the visitors said, "When we arrived we saw that she was with a female nurse, who was talking to her and being firm but fair. She was very kind. [The patient] said to her [nurse] 'Love I don't know what I would do without you being here'. The staff nurse in charge also explained why she had a staff member with her at all times and she stayed and explained about her care and her son being on holiday. It was good for us to know she is being cared for safely."

Staff were able to provide timely care to patients without being rushed. They took time to speak and engage with patients other than when they were carrying out specific tasks, for example checking patients in side rooms or providing one-to-one care and speaking to family and visitors about patients' needs. This had a positive impact on the experience of patients.

People said that they felt safe and at ease with staff. The majority of comments from patients were very positive. For example, one person commented, "All staff from accident and emergency through to the ward were excellent. Everyone has explained what is happening and when and I am up to date with my treatment." This showed that patients felt safe and cared for at the hospital.

## Are medical care services effective? (for example, treatment is effective)

There were systems to help staff provide care that was based on evidence and was clinically effective. Staff said they had access to specialist nurses. For example, on the gastroenterology wards staff were supported by nurse specialists in alcohol and substance misuse.

The trust had systems for responding to the findings of audits and quality improvement strategies in patient care. For example, on the acute stroke unit staff involvement in the urinary tract collaborative led to the introduction of a new bladder scanner.

The display boards on the wards we visited contained information about the effectiveness of clinical care at the

hospital. This included information about infection rates, and the number of patient falls and pressure ulcers. This provided a level of transparency to patients and visitors about the quality of the care provided.

Staff gave examples of how staffing levels were monitored and how the skill mix of staff was maintained. We were told that wards worked in 'hubs' or divisions which meant that only staff from acute medical areas such as renal, stroke or gastroenterology wards would cover within their specialist clinical area. We were told if some wards were overstaffed for their patient numbers, staff would be moved to those wards within the hub which required assistance.

We spoke to the lead nurse for acute medical services about how effective the department's staffing levels were in patient care. They said that matrons worked night duty as part of their roles and staff practice was monitored as a result. Nursing staff said that the trust's induction and mandatory training was effective and that ward managers monitored them regularly. We saw evidence that managers had used training audits and had received information to let them know when training was due. Staff told us that if they did not attend some mandatory training that was important to their role they could, under HR policy, be suspended without pay. They also said that they had 'link' roles within wards and this helped them develop and mentor junior staff.

Staff talked about the SCAPE (Safe, Clean and Personal Every Time) award, which is part of the trust's Nursing Assessment and Accreditation system. One ward manager said of the SCAPE standards, "It's changed the focus of nursing practice. The whole team is involved." The way SCAPE had been incorporated into the day-to-day work of the whole organisation was excellent – every member of staff could tell inspectors what it meant to them and to patients. One member of the administration team said, "I work in administration as a manager but understand what SCAPE means. As part of this, the trust wants to be the safest hospital in England. That's not a bad thing to aim for. I know the standards the executive board set and they are very visible. The director of nursing visits all departments including us. I live 16 miles away but would bring my family here first if they needed treatment." The benefit of SCAPE was evident in all the wards we visited.

# Medical care (including older people's care)

Recognised evidence-based guidelines were available (for example pressure ulcer prevention guidelines), and there was a programme of clinical audits across the trust. This indicated that staff had access to appropriate guidance and that the trust checked that they were using them.

## Are medical care services caring?

Staff were caring and tolerant, and they took time to talk to patients and explain what they were doing and why. For example, we saw a healthcare support worker using a patient's 'memory box' to help the patient discuss their life experience during the second world war. We also saw a registrar explaining to a patient and their family the results of a brain scan and how this indicated the patient may have had mini strokes. They were very reassuring and explained the immediate to longer term treatment the patient needed once their health improved.

Staff told us they were proud to work at the trust and said it was important to them that patients had as good an experience as possible when they were in hospital. One relative in the stroke service expressed concern over the care of a family member, and we advised that they raise this using the trust's complaints procedure. The ward manager confirmed that they had received the written complaint and they would respond to it.

There was information in patients' records which showed they and/or their relatives/carers had been involved in discussions about their care. Patients and relatives confirmed that staff had involved them and kept them informed. One family member said, "We were made to feel very welcome and staff will answer any questions. There is a lovely feeling of kindness," and another said, "I have been able to help my husband eat his dinner, even though there are protected meal times." Another family member told us that their relative's discharge had been delayed as a result of their health deteriorating and said, "I have now spoken to the nurse for the first time and feel he is safe."

Staff considered patients' wishes when planning and delivering care. They sought verbal consent when helping patients with personal care. On wards for elderly patients, we saw that patients were more involved and aware of their care plans. We spoke to staff about confidentiality in ward areas. Staff said they were aware that conversations

with patients in the bed bays could easily be overheard by other patients, and they spoke quietly when talking to people about personal or sensitive matters. We did not see any examples of patient confidentiality being breached.

Staff were considerate of people's psychological and emotional needs. For example, the teams on the stroke wards included a health psychologist to help people adjust to lifestyle changes following a stroke.

## Are medical care services responsive to people's needs? (for example, to feedback?)

We looked at how the trust responded to the cultural, linguistic and religious needs of patients. We asked how information about admission to hospital and care and treatment was provided to patients whose first language was not English. A member of the PALS team told us that patients could request information in their preferred format, but this needed to be done weeks before their admission to hospital. This information was not available on the trust's website. Interpreter and translator services were available, and staff told us that these services were accessible when they were needed.

The hospital provided a chapel and a prayer room for people with religious beliefs. Hearing loops were available for people who had impaired hearing. Patients had a choice of food, and there was a 'multi faith' menu available to cater for people's individual dietary requirements. This meant staff responded to patient's needs. We spoke to people before the inspection who confirmed that the trust respected their faith and provided a room and appropriate food.

The trust had systems and a multidisciplinary team for planning patients' discharge from hospital, and wards had discharge co-ordinators. In the discharge lounge, staff were managing patient discharges well and patients were not waiting for long periods.

We saw data that suggested that when discharge was delayed, this was usually because medication was not available at the time patients were ready to leave. As a result, the trust used a taxi service to take medication to

# Medical care (including older people's care)

patients at home, so they did not have to wait for medicines from the pharmacy. The trust had also provided a people carrier for patients who were mobile and did not have to use an ambulance to get home.

## Are medical care services well-led?

All staff were passionate about the care they offered patients and their families. There was clear, strong leadership and support for the service they delivered. Staff told us that the trust had encouraged housekeepers on the units to engage in the service quality improvement programmes in the hospital. Staff were encouraged to think of improvements and how they could be delivered. Staff said they felt empowered.

The lead nurse and ward managers told us that the trust had “good leadership” and that it kept them informed through various focus groups, a monthly leadership forum and governance meetings. They said they had regular contact with the senior management, the Chief Executive and Board members. They told us that the non-executive Board members walked around the wards on a regular basis. The majority of staff told us they knew who the Chief Executive and the Medical Director were.

The senior nursing staff said they believed the trust had a strong and effective culture of reporting serious incidents and concerns. They said they were confident that the trust listened to them and took their views into consideration. The ward managers told us they had regular contact with

their lead nurses, matrons and specialist nurse advisors. They all said they felt supported in their roles and valued the ‘fair blame’ culture within the trust. This meant that staff were more willingly to admit to mistakes and to learn from them, and also that they were able to share the learning within the wider organisation so that everyone learns and develops.

Services had a variety of ways of keeping staff informed. These included daily safety briefings called ‘safety huddles’, which took place three times a day when shifts changed. In addition, staff said there were staff meetings, a newsletter and the trust’s intranet, which staff could use to send questions to the executive team.

There were patient-centred initiatives in place. For example, on wards for elderly patients there were ‘what matters most to me boards’ at the end of patients’ beds. These contained information about patients’ personal needs. One nurse said these were a very good initiative and said, “These make the patient more of a person and they keep you in the picture.” This allowed all staff to understand what was important to the individual patient and enabled ward managers to measure that patients’ individual needs were being addressed. For instance, we saw on one board that it was important that that the patient watched the football being shown later in the evening. The use of the boards was to ensure that what was important to that person for the day (or the duration of their stay) was identified so that staff could make sure it happened.

# Surgery

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The surgical division includes the following areas:

14 theatres (with three more under construction)

- Surgical wards
- A pre-assessment unit
- A day case unit
- Neurology theatres
- Neurology wards

The hospital provides a range of surgery including orthopaedic, general surgery, neurosurgery and gynaecology. The surgical division has 195 beds.

We visited 4 theatres, day surgery, and wards B1, B2, B5, and B6.

## Summary of findings

- Surgery services provided safe, effective and well-led care.
- Staff were responsive to patients' needs.
- Three never events (events which should never happen) have occurred within the trust relating to surgical safety. The trust has looked critically at its practices and has set up the Theatre Safety Culture Collaborative. This will examine how the safety practice in theatre can be improved. The group is still in its infancy, but will report to the Board.

# Surgery

## Are surgery services safe?

Staff were appropriately trained to care for patients' specific needs, and they provided care in a safe and caring environment. Staff had carried out assessments, including risk assessments, to help them provide suitable care to patients needing specialist surgical attention.

Staffing levels were sufficient, with appropriate skill mix for the patients being treated.

Patients' clinical records were electronically maintained and all entries were timed and dated. This ensured all patients' records were complete, traceable and accurately completed and could be accessed from any point in the trust or PMS.

The environment was clean. In all areas, we saw that staff had used cleanliness stickers to identify when equipment had been cleaned and prepared for the next patient. One patient told us, "The place is really clean now. It never used to be, but now it's spotless."

In theatre, we found there was a learning culture which was open to constructive feedback and prepared to learn from incidents. The recovery team had recently achieved the SCAPE award which is part of the Nursing Assessment and Accreditation system and seeks to ensure that patient experience is 'safe, clean and personal every time'. It is judged against 13 standards and is reviewed at frequent intervals depending on the assessment. SCAPE wards are renewed annually unless indicated otherwise. Seven wards within the surgical division had achieved this award, and theatre recovery had also recently achieved it.

The trust is within the national average for slips, trips and falls (0.51% against a national average of 0.87% in August 2013). The wards were tidy and free from hazard. We saw patients asking for help with mobility, and staff helped them promptly.

The trust is also within the national average for pressure ulcers at August 2013, recording a score of 0.94% against a national average of 1.09%.

In line with trust policy, all incidents and errors were fully investigated and learning was shared electronically across the trust – not just in the area the incident occurred. This ensured the learning culture was maintained cross the trust.

The department applied the surgical venous thromboembolism pathway, designed to reduce the incidence of thromboembolism, including Deep Vein Thrombosis (DVT). The trust rate for DVT fluctuates below and above the national average. We discussed this with the ward manager, who could not attribute this to any contributing force.

Patients' views on the food provided were varied. Some said it was excellent and others said it was bland and not very appetising. During our inspection, we saw that food was hot and well presented. The department used red trays to identify patients who needed help with eating, and this prompted staff to help patients. Drinks were available, and one patient told us, "We can always get a lovely hot drink on this ward. If I have a visitor here, they always get offered a drink too."

## Are surgery services effective? (for example, treatment is effective)

Patients felt that the trust had addressed their care promptly and had arranged and carried out surgery without setbacks. Patients were mobilised at an early stage to minimise the risk of DVT and to ensure that they were back to full mobility as soon as possible.

Patients felt that their journey through the operating theatre had been caring and that staff had maintained their dignity. They said that staff had spoken to them in a caring manner and had been sensitive to their needs. One patient told us, "Staff, when I woke up, were so kind to me and explained fully what they were doing, even though I didn't remember afterwards. Nothing was too much trouble for them."

Operations had been carried out on the planned date for the patients we spoke with. Although some had been delayed, they told us that staff had generally kept them informed of the delay. One relative told us that they had called the hospital and a member of staff had explained that their relative had been late going to theatre. The staff member had said that they would call them back when the patient returned to the ward, and they did.

The departments all had staff meetings on a regular basis to share information. This ensured all staff were up to date on all changes currently affecting the trust.



# Surgery

Patients confirmed that they saw their consultants and doctors at ward rounds. But they also said that they saw them at other times and were able to ask questions.

One patient told us that their relative had also had an appointment to see the consultant to discuss their care and had been very satisfied.

## Are surgery services caring?

Staff reacted to patients' needs in a prompt and friendly manner. They answered buzzers as soon as possible. Patients told us they sometimes had to wait a short while but the nurses always came and assisted them and they were never curt with them.

Staff treated patients and families with dignity and respect, and they spoke to them in a caring and friendly manner. Patients said that staff were always cheerful even though they appeared very busy. They felt respected and cared for. One patient told us that she felt very safe in the nurses' care and would miss them when she was discharged.

Patients in theatre were treated with dignity, and staff explained the care they were about to receive so that they fully understood it. This ensured patients gave informed consent.

The wards were adequately staffed to care for the needs of the patients. Where possible, patients were sat out of bed and looked well cared for and comfortable. We found nurses were available to address any issues patients had within the bay they were being nursed in.

Services adhered to single sex accommodation regulations, and there was signage for male and female bays and bathrooms in line with national guidance.

One patient in theatre had to have their treatment postponed due to a clinical issue. The anaesthetist gave them a full explanation of why they had to postpone treatment and the patient was transferred to recovery for a short period of time so that staff could monitor them before surgery began.

We saw that staff closed curtains and doors when patients were being examined.

Patients told us:

"It is like a hotel here. The nurses are excellent."

"I have had all my needs met in a caring manner. The staff are wonderful, both on the ward and in theatre. I was very nervous, but they spoke to me in a caring manner and eased my concerns. The same nurse saw me when I woke up, just as she promised she would"

"I was concerned my relative would be worried about me, so the nurse who woke me up after the operation rang her for me to tell her I was ok. That's service."

"I have never all the way through my hospital stay seen a miserable face."

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

Staff responded to the needs of patients in a timely manner and always gave a full explanation of what was happening.

Patients told us that once they had arrived on the ward everything seemed to move quickly, and they had had their surgery or treatment as required. One person told us, "The consultant was very approachable, and when I explained my past history I felt he listened to me even though he probably knew better than me."

The trust complaints procedure was available to people who wanted to make a complaint. One person told us that they felt no need to complain, but if they did they would speak to the nurse in charge and were confident they would address the issues for them.

Positive inpatient response rates for the Friends and Family Test (which asks patients if they would recommend the services to people they know) were below average for three out of the four months between April and July 2013. In July 2013, 430 people completed and 90.4% said they were 'extremely likely' or 'likely' to recommend the ward they stayed in to family and friends.

In theatre, we saw staff taking care to ensure the patients were comfortable before beginning the anaesthetic. They also asked patients if they had any questions. We noted in the recovery area there were two rooms where patients who required extra care could be nursed to allow them privacy and dignity or enhanced care.

# Surgery

In theatre, we saw that a family had given feedback on their experience within the department. In response to this feedback, the department had made changes, and the family was due to visit the department again to look at the changes.

## Are surgery services well-led?

We spoke to the senior management team in theatres, and they explained their roles in supporting the team including ensuring that staff, where possible, had regular breaks.

We saw documentation that showed that the trust investigated and reported on all clinical incidents. It shared findings at team meetings across the division to ensure that everyone was aware of the subsequent action plan and how to try to ensure the incident did not occur again. Theatres had a 'fair blame culture', but learnt together from incidents and supported staff to identify what went wrong and how to address it. We were informed that any complaints or incidents were investigated by the senior team first, but the family and patient were involved if they wanted to be. This was part of the open and transparent culture within the hospital. We saw evidence that the theatre had recently had a serious incident and had involved the patient and family in the investigation process.

Despite the introduction of the World Health Organisation's Safer Surgery Checklist, three never events relating to surgical safety have occurred within the trust. To address these issues, the trust had looked critically at its practices and set up the Theatre Safety Culture Collaborative. This collaborative will examine how to ensure a positive safety culture within the theatre suites. One team per surgical specialty will make up the team to allow the collaborative to design solutions that cover the total patient journey. This group is still in its infancy but has support from the Board through to all levels of staff.

There was effective communication between all grades of staff throughout the division, and we saw staff supporting each other, regardless of grade.

The senior management team was highly visible in the department, and all staff recognised them.

Each ward had a ward manager or matron responsible for the day-to-day management of the wards. They had support from the lead nurses and Assistant Director of Nursing Services.

Theatre had recently changed its internal structure to reflect the clinical area and had changed the titles of the senior staff from managers to clinical leads. This reflected the specialities within the department and ensured that staff could get support from the appropriate person rather than be passed through a few people before reaching the correct person.

The theatre team and trust had supported a number of healthcare support workers in completing a foundation degree in health and social care which included theatre specific competencies. This group of staff was now, under supervision, assisting during minor surgical procedures. This freed up more senior staff to be available for more complex surgical procedures.

Training within the division was up to date and staff requiring professional registration all had their registrations checked for expiry. Appraisals were ongoing, and clinical leads monitored personal development plans.

There was positive communication between medical and nursing staff, and all members of the team were involved in discussions about pressures on the service. An example of this was discussions concerning an operating list that would run past its agreed completion time due to unforeseen circumstances; all staff were involved to agree an outcome that would assist the list to be completed out of its regular allocated hours. Staff agreed to stay after their duty time to ensure patients were not cancelled and their surgery was completed in a timely manner, which resulted in staffing being agreed to ensure that the list could be completed.

A whistle blower contacted us on the first day of inspection with concerns about staffing levels and the competence of staff for a specific operating list. We discussed this fully with the senior team in theatre. They showed us documented, dated, email evidence of how this list had been planned in advance and how staff who were to work on the list had been consulted and agreed to being part of the team. The emails also identified the staff members' names and previous experience in the clinical speciality, which assured us that the staff were occupationally competent to be part of the team. We did not find any evidence to substantiate the whistle blower's concerns.



# Intensive/critical care

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The Critical Care service is provided across three units: Intensive Care, Neurosciences High Dependency Unit (NEURO HDU) and Surgical High Dependency Unit (Surgical HDU).

We visited the Critical Care Unit, HI Medical High Dependency Unit/Renal High Dependency Unit.

## Summary of findings

The critical care service provided safe, effective and well-led care.

Staff were responsive to patients' needs. The units were calm and staff supported people who had questions about their own or their relative's care.

The Critical Care service was situated in a purpose-built and fully equipped facility.

There were sufficient numbers of suitably qualified staff to meet the needs of people in critical care and provide safe care.

# Intensive/critical care

## Are intensive/critical services safe?

The Critical Care service was situated in a purpose-built and fully equipped facility. Staff provided care in a mixture of open bays and private side rooms. Half of the beds available were in private side rooms. This mix of bed space enabled staff to manage infection prevention control and single sex accommodation effectively. The infection rates on the unit were very low which showed us that the service had a proactive approach to managing infection and prevention control.

Staff assessed people's individual care needs and planned care to meet those needs. Records were complete and comprehensive, so that care could meet the needs of the individual.

We saw a copy of the critical care passport, which recorded information about a patient's personal needs and was used in all the critical care areas. It included information on dietary preferences, religious/spiritual needs, sleep patterns and any communication issues. The information was used to ensure that care was personal and comfortable. This showed us that staff were able to meet the specific needs of individuals receiving critical care.

There were sufficient numbers of suitably qualified staff to meet the needs of people in critical care and provide safe care. Staff were responsive to changes in the dependency of patients across all areas and were able to work across both intensive care level 3 as well as the high dependency level 2.

The department had two advanced nurse practitioners. They had had a positive impact on patient care by carrying out non-medical prescribing and working with other staff to ensure pain management within all critical care areas was well managed.

Medical staff told us that during staff shortages they always used locums who had previous experience of working on the units. All locum staff had a thorough induction into the various areas within the department.

Processes were in place for ensuring that as patients' needs changed they could be managed and nursed in the most appropriate setting. This included moving into and out of ICU into HDU at short notice. Staff told us that patients who no longer required intensive treatment and care were moved to the ward in a timely manner to ensure that they

were not in critical care longer than necessary. The service had a target of moving people off critical care within 24 hours of the decision to move. Audits we saw showed that this target was achieved almost one hundred per cent of occasions and staff told us that these patients were given priority by ward staff.

The trust had been proactive in developing clinical pathways for acutely unwell patients, and it had developed early warning systems and pathways to help staff provide timely treatment that is appropriate for individual patients.

Staff used a 'safety huddle' each morning to hand over safety information about patients and update staff on patient's clinical status. Staff on all units had regular update meetings to ensure everyone was aware of changes in individual patients' needs.

Critical Care staff carried out 'intentional rounding', which reviews patients at hourly intervals. This ensures timely and effective management of any changes in their condition.

Critical care indicators for the service were positive, showing that 100% of patients were free from new harm between September 2012 and September 2013. Quality performance boards were clearly visible in the unit, indicating that no grade 3 or 4 pressure sores had been acquired over the previous 12 months.

## Are intensive/critical services effective? (for example, treatment is effective)

The trust submitted data to the Intensive Care National Audit and Research Centre (ICNARC). Recent staff sickness had meant that its recent submission had been delayed, and plans were in place to ensure that the data would be inputted as soon as possible. ICNARC data is a corner stone of national critical care benchmarking and therefore its review and interpretation is an essential part of assessing the effectiveness of critical care performance. Despite the information not having been submitted, the trust was able to provide data on previous reviews of the service, and we saw records of regular monitoring of the effectiveness of the service. The lead nurse described the process of disseminating information to different levels of staff. This included data on length of stay, infection control rates, pressure ulcer rates and bed occupancy.

# Intensive/critical care

Staff provided care and treatment based on guidance issued by professional and expert bodies such as National Institute for Health and Care Excellence.

The lead clinician told us that surgery was rarely cancelled due to the lack of an intensive care bed, and transfers out to other hospital units was also rare. This showed us that the service was managing its resource effectively and did not need to move people to other units.

Senior staff outlined the progress made towards full integration of staff across critical care, which gave them greater flexibility to effectively manage capacity and demand.

Staff told us that they had access to regular training and had the skills and knowledge required to carry out their job roles. We were told that a senior nurse consultant was involved in reviewing the treatment of specific patients with airway management issues on the wards to ensure that the most appropriate care and support was available.

The Critical Care service was actively involved in the trust accreditation schemes and had received the SCAPE award, which is part of the Nursing Assessment and Accreditation system. This programme seeks to ensure that every patient experience is 'safe, clean and personal every time'.

## Are intensive/critical services caring?

Staff treated patients and relatives with dignity and respect. They maintained patients' privacy and dignity closing doors and using 'do not enter' signs on cubicle curtains to restrict access, where necessary.

The units were calm and staff supported people who had questions about their own or their relative's care. There was a reception area for critical care, where relatives could be greeted before going into the unit. There was a dedicated waiting area for relatives.

Staff had an excellent approach to bereavement. We saw that care and compassion were offered to a family who had just been bereaved. We were told of the specific actions that had been carried out to meet the final wishes of a patient who had recently passed away. Members of the chaplaincy team told us how they worked closely with the critical care staff and the bereavement team to ensure that support was given throughout the patient's end of life journey. A number of excellent examples were given to us

which showed an exceptional caring attitude from staff, such as a placing the belongings of the patient into a special bag awaiting collection from relatives. The bags have been specially selected for their colour and pattern to recognise the individuality of the patient and for the relatives to feel that their loved ones are taken care of even in death. This may seem like a small gesture, but it was so appreciated by relatives for the thoughtfulness it showed.

Patients we spoke with were very happy with the care they had received. One said, "Staff are great. I choose to come back here for my care."

## Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Staff were encouraged to be responsive to the needs of individuals. We were told of examples of how staff improved the critical care experience for longer term patients, including by allowing friends to come in and relax with a person who was at the end of their life. We were told of one young person who wanted his friends to come in and have a drink with him, to enjoy his company and for him to feel part of his friendship group while in hospital. This was supported by staff and acted on.

The senior nurse did daily rounds of all patients, talking to them and their families to ensure that staff were meeting their needs. Any decisions regarding the withdrawal of treatment were fully discussed with both the family and the full multidisciplinary team. Staff then documented this on the electronic care records.

The department had daily situation report meetings to ensure that all the areas across the trust were aware of any capacity issues. There was a ward base from which staff see the current status and availability of beds across critical care. This helped staff in planning their workload and responding to needs appropriately.

We were told, and records demonstrated, that all the patients discharged from the service were followed up and a questionnaire was completed after discharge home, if appropriate. Feedback from the questionnaires was given to the Patient Experience Collaborative, which includes members of the critical care team. One staff member told us they were continuing to ensure patients and relatives had all the information they needed and that they

# Intensive/critical care

continued to seek ways of improving communication. The use of the critical care passport was an example of how the units had put in place a process to improve communication.

The service had clear links with the Greater Manchester Critical Care Network and was involved closely in discussion regarding regional updates and change to capacity.

The service was proactive in having visiting clinicians and managers to the service to share best practice and continually improve the quality of services.

## Are intensive/critical services well-led?

The Critical Care service worked in close partnership with all areas across the trust. There was both medical and nursing leadership, and the service was well-led.

All staff were passionate about the care they offered patients and their families. There was clear leadership and support for the service they delivered.

We saw examples of team work across all job roles. Housekeepers had been encouraged to engage in the service quality improvement programmes and had been proactive in producing savings in the equipment budget. This showed us that all staff were encouraged to take on a leadership role and be engaged in working towards the trust values and visions. There was a clear vision for the future plan of the service, and although the staff acknowledged they had not reached the end, they were confident and passionate about becoming a fully integrated critical care service.

# Services for children & young people

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

Children's services at Salford Royal Hospital are based in the PANDA Unit (Paediatric Assessment and Decision Area), which provides dedicated emergency and short stay care for children younger than 16. This is a consultant-led service within which children can be assessed, investigated, observed and treated within 24 hours without recourse to inpatient areas.

The PANDA children's unit has a minor injuries area with a seated area and a four-bedded bay area. The unit also has eight single cubicles, including two with en suite facilities and one with high dependency equipment.

In addition to the children's unit, the Salford Royal Hospital also provides paediatric ear, nose and throat (ENT) day surgery, paediatric dental, gynaecology and dermatology clinics.

We visited the PANDA emergency and assessment unit.

## Summary of findings

- Paediatric services provided safe and effective care. Staff were caring and the service responded to patient's needs.
- Patients (and relatives) we spoke to were complimentary about the care they received and how it was delivered. The service was well-led.
- Maternity services are not provided at the trust.

# Services for children & young people

## Are services for children & young people safe?

The children's unit monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to staff, patients and visitors to the unit. All incidents, accidents, near misses, never events (mistakes that are so serious they should never happen), complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff in the unit had access to the electronic risk register. The trust used monthly clinical governance meetings to monitor and review departmental risks. The Unit Manager and Consultant Paediatrician told us that staff received feedback about incidents that had occurred within the service so that learning could take place.

All areas of the unit were clean, safe and well maintained. 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. We also visited the paediatric day surgery unit and found this to be clean, safe and well maintained.

The unit maintained its own equipment store, and staff could also access the equipment they needed from other parts of the hospital. Staff told us they always had access to equipment they needed to meet patients' needs. The equipment we saw was clean, safe and well maintained.

The trusts' estates department was responsible for maintaining equipment. Maintenance concerns were logged via an electronic system and prioritised based on risk. For example, a failure of the auxiliary or life support systems would be flagged as a high priority and responded to immediately.

Staff told us they used single-patient-use, sterile instruments where possible. These were stored appropriately. There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a sufficient number of hand wash sinks in the unit.

Staff were trained in a paediatric discipline or specialty so they understood the specific risks associated with treating

children. We saw there was a sufficient number and skills mix of trained clinical, nursing and support staff on the unit to ensure patients were safe and that they received the right level of care.

The unit was equipped with emergency equipment and a high dependency room. Medicines, including controlled drugs, were securely stored. Medicines were stored in a dedicated fridge and staff were responsible for recording fridge temperatures daily. Staff were also responsible for carrying out daily checks on controlled drugs, and emergency equipment and medication.

Staff did not always correctly complete daily checklist forms for recording fridge temperatures and equipment checks. Some policies and procedures within the unit were also out of date and needed review. We discussed this with the Senior Manager, who told us they would take appropriate actions to address the documentation issues.

## Are services for children & young people effective? (for example, treatment is effective)

Staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Performance data between April 2013 and October 2013 showed that over 95% of patients were seen within four hours.

There was an effective triage system in place to assess and prioritise patients based on need. All patients were triaged at the accident and emergency (A&E) department and then transferred to the unit if they required further assessment or treatment. Patients and their relatives told us they were seen by a triage nurse within 30 minutes. A paediatric nurse triaged patients in A&E between 1pm and 9pm on weekdays. Patients needing urgent medical attention were given priority over non-urgent cases.

We spoke with the parents of an infant, and they spoke positively about their experience. They told us their child was triaged and immediately transferred to the unit for treatment.

Staff meetings involving all disciplines took place on a regular basis to ensure effective communication and knowledge sharing. Staff handover meetings and safety

# Services for children & young people

huddles took place three times daily to ensure all staff had up-to-date information about risks and concerns. Staff were aware of the process for escalating concerns such as increased waiting times and bed capacity.

The Consultant Paediatrician told us the paediatric clinical team met routinely to discuss research and current best practice guidance. The children's service directorate clinical governance meetings took place monthly. These were chaired by the Clinical Director and attended by the senior staff to discuss information such as risks, completed audit findings and research and new clinical guidelines.

## Are services for children & young people caring?

The department discussed patient feedback during routine staff meetings. Patients and their relatives spoke positively about their treatment by clinical staff and the standard of care they received. They told us that staff kept them fully involved and clearly explained their care planning, treatment and discharge to them. The comments received included "nice, clean and friendly" and "perfect".

Staff interacted with patients and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure patients' privacy and dignity. For example, the bay area had partition curtains, and there were eight single room cubicles in the unit to allow for privacy.

Staff had the appropriate skills and knowledge to seek consent from patients and their relatives. Consent was sought from children's parents, representatives or legal guardians in most cases. Consent was obtained in line with 'Fraser guidelines', which provide guidance on how to seek consent from children and young people. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved other healthcare professionals. Staff understood the legal requirements of the Mental Capacity Act 2005.

Staff had a person-centred approach when providing care and treatment to patients. Care and treatment were based on individual needs and preferences. Patients and their relatives had a choice of food and drink during their stay.

The unit also had feeding bottles and a selection of baby milk formula in case it was needed. The parent of a patient commented that "we have been very well looked after by the staff".

Staff gave patients and their relatives information about their care and treatment. There were other information sources, such as leaflets and notice boards. These had information about approximate waiting times and staffing levels and were clearly visible. However, the information was not available in languages other than English. The trust informed us that their current system to ensure that information leaflets are available in multiple languages was developed with the city council. Each leaflet gives an explanation describing how to obtain a version in the five most commonly used languages in the Salford area. A leaflet in the preferred language can be obtained within 24 hours. The trust said they have not received any complaints about this provision which suggests it is effective.

Patients and their relatives told us they received sufficient information relating to care and treatment once they were seen by the clinical staff in the unit. The waiting area was not permanently staffed. However, staff monitored this area through a closed circuit (CCTV) camera to ensure people were safe.

We saw a large selection of children's toys and games across the unit. The waiting area also had a small play area. There were two play therapists in the unit who were responsible for maintaining activities for patients. One patient told us the activities and toys were more suitable for younger children and there were not enough activities for older children. We discussed this with the Senior Manager, who confirmed they would look to provide more activities across the full age range of patients.

## Are services for children & young people responsive to people's needs? (for example, to feedback?)

Qualified clinical or nursing staff reviewed and investigated serious incidents to identify potential causes and identify areas for improvement. Findings were shared with staff in the unit to improve understanding and aid future learning.

The trusts' children services were fully integrated with community based services. The divisional Clinical Effectiveness Committee included clinical leads for the



# Services for children & young people

community as well as representatives from the children's unit. The unit had a team of children's community nurses that supported integrated care between the trust and primary care services. The Consultant Paediatrician also carried out clinics within the community to ensure integrated care. This showed that staff were responsive to people's needs within the local community.

The unit has a dedicated short stay area for patients providing assessment and treatment up to a maximum of 24 hours. If a patient needed to stay longer, this was logged as an incident. Staff confirmed this had only occurred once during the past six months. There was an effective discharge process, which involved the children's community nurses to ensure continuity of care. The unit had arrangements with at least two other local trusts to ensure patients could be transferred if they needed care for longer than 24 hours.

The unit had systems in place to meet people's religious and cultural needs. Staff had received mandatory training in basic conflict resolution and equality and diversity awareness. Staff understood people's cultural needs. For example, the food menu included 'halal' or 'kosher' options. Staff had access to an interpreter service, if needed. The trust planned to actively engage with the Manchester Jewish Federation to seek its input in order to improve services for Jewish people.

Staff on the unit told us all complaints were recorded on the trust-wide electronic incident reporting system. Ward staff investigated formal complaints. The Consultant Paediatrician and Unit Manager told us they had received two complaints during the past six months and these were investigated and responded to in a timely manner. We saw that Patient Advice and Liaison Service (PALS) leaflets were available in the waiting area. Patients and their families told us they did not have any concerns about the service they received.

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

There was an effective clinical governance system in place that allowed risks to be escalated to divisional and trust Board level through various committees. All staff on the children's unit attended fortnightly staff meetings to discuss the running of the ward and to share information. The paediatric consultants met monthly or bi-monthly to discuss matters relevant to their role. The Senior Manager and Lead Consultant also monitored performance during monthly children's service directorate clinical governance meetings, which was chaired by the Clinical Director and attended by the senior staff.

The children's unit had clearly defined leadership roles. There was a lead consultant to oversee clinical staff. The Unit Manager was a paediatric nurse and oversaw the nursing and support staff. The Unit Manager and Lead Consultant reported to the Senior Manager and Clinical Director respectively. The unit had identified staff with specific lead roles, such as a safeguarding lead and an infection control lead.

Staff were positive about the support they received from the management team. Staff said they were supported with additional learning and practice development. Training data showed that the majority staff had completed their mandatory training and annual appraisals. Staff monitored key processes, including clinical audit, medicines and infection control. We looked at recent audit records, which showed that actions plans were put into place to address areas of concern and these were followed up.

The Unit Manager told us they had positive working relationships with various other departments within the trust. The children's unit was integrated in the emergency department and shared triage services. Staff from A&E routinely worked on the unit to gain experience in paediatric care.

# End of life care

Safe

Effective

Caring

Responsive

Well-led

## Information about the service

The trust has a dedicated palliative care team led by both medical and nurse consultants. Palliative care is provided across the hospital. The service is provided five days a week with access to specialist advice out of hours. The hospital specialist palliative care multi-disciplinary team provides direct patient care where palliative care needs are complex and cannot be met by the hospital and /or primary care team. It also provides indirect patient care through advice and the education of general medical/surgical colleagues (including the development and implementation of patient pathways).

The trust also has a bereavement service, which is situated on the ground floor of the hospital for people to get support during end of life care and after the death of a relative. It offers both practical and emotional support.

We visited three wards which provided end of life care.

## Summary of findings

- The management of end of life care was well embedded across the trust. End of life care has clear clinical leadership and staff engagement.
- Staff were passionate about end of life care and the need to engage with individuals and their families.
- The trust had a clear strategy for responding to concerns regarding the Liverpool Care Pathway. It was committed to ensuring that end of life care was based on individual need and that all care was taken to ensure that people were fully involved in every part of the process.
- Robust mechanisms were in place for adhering to local and national standards for end of life care.
- We heard many examples of excellent practice in helping patients to die with dignity and in accordance with their wishes, in supporting family, friends and staff following a patient's death.

# End of life care

## Are end of life care services safe?

Records demonstrated that staff were aware of the need to follow the national standard of care for end of life. Records were accurate and complete, which demonstrated that staff were aware of the need to ensure that the end of life care package was followed in line with patients' wishes. The care plans standard had clear guidance on both the management of pain and supporting individual spiritual needs.

The trust had clear expectations of the documentation that should be used in end of life care, including the process for the verification of death and care after death. We saw the process for starting and co-ordinating the rapid discharge pathway for care of the dying. This showed us that every effort was made to ensure people were able to leave hospital and end their life in a place of their choice, with all the appropriate equipment and support as required for a safe discharge.

Staff regularly consulted colleagues about patients' end of life care plans. Staff said they had regular conversations with patients and families to ensure they were well informed of ongoing care plans. Records showed that these conversations were indeed taking place. The plans included clear documentation for requests not to be resuscitated and for ensuring that patients and their family were getting the necessary support and comfort. This showed us staff were able to provide the most appropriate care to patients.

Wards also carried out 'intentional rounding'. This process ensures that each patient is reviewed at set intervals. The needs of end of life care were fully integrated into this process.

The palliative care team had a weekly meeting to review every new referral to the team. Any information from this meeting was entered into the electronic record 'coordinate my care'. This ensured that staff recorded all relevant communication and identified needs and that staff were fully up to date with the needs of the patients in their care.

Staff were able to describe the training that was available to enable them to have the skills to carry out their job roles. Bereavement training was carried out monthly. More in-depth training was available every six months to staff who

wanted to gain further skills in end of life care. All staff across the trust welcomed the introduction of the bereavement service, which they saw as a positive resource.

We saw the pathway that the trust used for patients in the last few days of their life. The trust had produced guidance for staff on how to manage the process, and it continued to use the existing pathway unless families raised concerns. The team told us the trust had carried out an audit to assess compliance with the pathway. The results of the audit were not available at the time of the inspection.

## Are end of life care services effective? (for example, treatment is effective)

Every week, the palliative care multi-disciplinary team met and reviewed all new referrals, latest assessments and any recent deaths. If a patient had not been supported by the team, there was a mechanism for following up on the case and ensuring that a named person provided bereavement support. The team then investigated and reviewed the oversight as part of its learning cycle. At the time of our visit, the trust was investigating a complaint about a patient's discharge arrangements. The trust also told us of other forums for reviewing deaths across the trust which told us that they had robust arrangements in place to monitor end of life care across the trust.

One ward had a palliative care link team which included all grades of staff. Staff from the ward told us they had plans to work with the palliative care team to gain more experience and develop skills in this area. As part of their work they had introduced a relative comfort box, which included essentials (for example a toothbrush) that people would need when visiting their loved ones on the ward.

We met members of the newly established bereavement service and visited the bereavement centre. Staff were able to provide a range of emotional and practical support to people during and after the death of a loved one. For example, they arranged visits to the mortuary, ensured that the death certificate was available in a timely manner, provided bereavement counselling and helped people liaise with the coroner. Staff were also able to provide personal artefacts such as a hand print or a lock of hair.

Staff were very dedicated and committed and told us they tried to be available for a couple of days after a death. The

# End of life care

nurse who had provided care and be known to the family would phone a relative to ask if they had any questions or concerns. The bereavement nurses also provided regular training for staff and worked closely with the palliative care team to ensure that it offered a high quality, effective service for end of life care. This thoughtfulness from staff who had provided care was said to be appreciated by relatives.

One ward was trialling the use of ‘amber bundles’, which is an approach that hospitals use when they are uncertain whether a patient will recover and are concerned that they may only have a few months to live. The trial will help to help the understand how best to manage people who may require palliative care, and how to assess and best engage with them at the appropriate stage of their illness to ensure that they get appropriate care in a timely manner.

Staff told us that the recent national review of the Liverpool Care Pathway had focused people’s attention on ensuring that people had the right spiritual care. We were told of specific examples when end of life rituals had been provided for patients with a variety of religious and secular needs.

Following the national review, the trust had been proactive in reviewing its use of the pathway and how to respond to the review’s recommendations. The palliative care team had presented a paper to the trust Board, outlining future plans and an action plan for implementation of all the recommendations.

Each ward took part in an accreditation process to drive quality improvement. As part of this process there were a number of different core nursing standards, one of which was for end of life care. This ensured that staff were able to demonstrate that they understood how to manage end of life care effectively in line with best practice, and local and national guidelines.

One person said, “I know everything that is going on,” and another told us, “The staff are always around.”

## Are end of life care services caring?

Staff treated people in a caring and respectful manner. They were proactive in ensuring privacy, and put signs on

curtains to remind people not to enter a cubicle, where necessary. The bereavement team told us about memorial services it was planning for relatives and the care and support it had offered to people.

In one unit, we saw staff providing support in a caring and compassionate way and trying to ensure a person’s last wish was met while offering support to the family. Staff made every effort to try to support patients’ last wishes. For example, we were told that they had arranged a pyjama party for a gentleman and his grandchildren.

We were told that the chaplaincy service was also regularly involved in escorting people to the mortuary to ensure that they were supported with specific spiritual needs.

We were also told and saw evidence of cards that nurses sent to relatives of patients they had looked after. We also saw feedback from the families stating that the cards had brought them comfort.

The majority of comments about the service were positive. However one person told us, “Some staff are good, some not so good.”

## Are end of life care services responsive to people’s needs? (for example, to feedback?)

The palliative care multi-disciplinary team worked across the hospital and in community settings, as well as at the local hospice. This demonstrated its close working relationships and ability to communicate well and respond in a timely manner to a person’s changing needs.

Team meetings included an education section during which staff were able to discuss any clinical uses and review any lessons learned from previous patient journeys.

The trust clinicians told us that they had been part of national review of the Liverpool Care Pathway so had been proactive in reviewing it and presenting a paper to the trust Board on how it should respond to the review’s recommendations. They aimed to include the end of life audit tool information as part of the mortality review to ensure that it was embedded across the trust.

# End of life care

We saw evidence of the national care of the dying audit which had been reported to the governance group. This showed us that the team was responsive to any updates and had processes in place to monitor and ensure improvement in issues identified.

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

The trust's dedicated palliative care team consisted of both medical and nurse consultant leads. The team was well praised and valued across the trust, and staff were positive in their comments. One person said, "They are always there for advice and support."

Palliative care and end of life care were promoted in a positive manner across the trust, and the introduction of the bereavement service and a bereavement nurse were universally welcomed and felt to be innovative in end of life care.

The Assistant Director of Nursing Services and all the members of the bereavement service were passionate about supporting both families and staff in end of life care.

All the staff we spoke with were passionate about the care they offered patients and their families. There was clear leadership and support for end of life across the trust. On one ward, a healthcare assistant had taken the initiative to produce a DVD about what end of life care meant to them and staff on the ward. This showed the enthusiasm and passion for end of life care on the ward and was used on the ward to help patients and staff.

# Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Information about the service

The outpatients department has clinics across a range of clinical specialities, providing services to over 300,000 patients annually. Additional services, such as neurological and dermatology outpatient services were also provided from a number of sites across the Greater Manchester area.

We visited the outpatients department.

## Summary of findings

The outpatients department provided safe and effective care.

Staff were caring and the service responded to patients' needs. Patients said staff treated them well.

Patients said they received information about their treatment so they understood what was happening and that delays to appointment times were kept to a minimum. The service was well-led.

# Outpatients

## Are outpatients services safe?

The outpatients department monitored and minimised risks effectively. Staff were aware of the process for reporting any identified departmental risks. All incidents, accidents, near misses, never events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff in the unit were aware of, and had access to, the risk register.

The areas we visited were clean, safe and well maintained. 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. Staff cleaned treatment rooms daily, and there were signs on the doors stating when each room was last cleaned. Patients spoke positively about the cleanliness in the department.

Staff in the ear, nose and throat (ENT) outpatient clinic had clear instructions for the cleaning and decontamination of flexible nasendoscopes, which are used to examine the palate (roof of the mouth) and throat. There was an action plan in place to address areas where the decontamination process did not fully comply with national guidelines.

There was an adequate number of hand wash sinks in the consultation and treatment rooms. Two sluice rooms did not have dedicated hand wash sinks. The Nurse Manager told us that the staff either washed their hands in the utility sink or in the adjacent treatment rooms.

Staff gave patients effective, safe and appropriate care. Treatment reflected patients' needs, preferences and diversity. Qualified staff carried out the analysis of diagnostic tests and assessments. There was a sufficient number of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.

Staff told us they used single-patient-use, sterile instruments, where possible. Staff had access to emergency resuscitation equipment and medicines in case of a medical emergency. To protect patients from abuse, there were safeguarding leads in the department. Staff received mandatory training in adult and child safeguarding so they could identify, report and respond to allegations of abuse.

Staff did not always correctly complete daily checklist forms for recording fridge temperatures. Staff were also not clear on what steps to take if fridge temperatures exceeded the maximum range. We discussed this with the staff, who told us they would take appropriate actions to address this issue.

## Are outpatients services effective? (for example, treatment is effective)

There were effective clinical governance arrangements and appropriate systems in place for the reporting and management of risk. There were clear processes for escalating risks to the trust Board, where required. The department had implemented a three-year outpatient improvement strategy, which aimed to deliver improvements in patient experience. The strategy involved reviewing best practice literature, healthcare innovation and improvements to the appointments process. One patient told us, "I've been coming here for years and there have been lots of changes and improvements." Another patient told us, "I can see the improvements in treatment."

There were regular staff meetings involving all disciplines to ensure effective communication and knowledge sharing. Staff handover meetings and safety huddles took place each morning to ensure all staff had up-to-date information about risks and concerns.

A nurse coordinator carried out hourly 'intentional rounding' observations across the outpatients department to check patient, staff or clinic issues, adverse incidents and vulnerable patients. The nurse coordinator also carried out daily checks on staff rotas and emergency equipment. This allowed the staff to identify any areas of concern so they could look to improve services. Staff were aware of the process for escalating concerns such as increased waiting times and staffing issues.

The majority of patients came for routine appointments. Staff provided patients with drinks if they had waited longer than one hour. There were separate reception areas for patients arriving and those that were leaving the department. Patients were given a follow-up appointment date before leaving. Staff told us this helped to reduce queues in the reception areas.



# Outpatients

## Are outpatients services caring?

Patients spoke positively about the care and treatment they had received. One patient told us, “This is the best hospital, not the nearest but it has the best doctor for my condition.” Patients told us that staff were helpful and provided regular updates if there was an increase in waiting times. Approximate waiting times were displayed in each area we visited.

Patients were given enough information about their treatments to help them make informed decisions. Patients told us that they received information in a way they were able to understand. Information leaflets were available for people in the waiting areas. However, these were not available in various languages. There was also an interpreting service. The comments received included “The consultant explained everything and asked relevant questions” and “received good communication prior to appointment”. This showed staff cared about meeting patients’ individual needs.

Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff sought verbal consent for the majority of treatments. They sought written consent from patients prior to administering local or general anaesthetic and prior to performing some invasive procedures.

Where a patient lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient and involved other healthcare professionals. Staff understood the legal requirements of the Mental Capacity Act 2005. In the case of a child patient, consent was sought from their parents, representatives or legal guardians in line with the ‘Fraser guidelines’, which set out how to obtain consent from children.

Staff respected patients’ privacy and dignity. Consultations took place behind closed doors. The consultation rooms were separated from examination or treatment rooms. Where this was not possible, curtains were put in place to allow for privacy.

Staff received mandatory training in conflict resolution, dementia awareness and equality and diversity awareness. They engaged with patients and their relatives in a polite,

friendly and respectful manner. Patients were complimentary towards the staff. The comments received included “staff are helpful” and “there is good communication from staff with updates”.

Volunteers were available in the department to support patients and guide them to the correct clinics. This demonstrated the service was patient-focused.

## Are outpatients services responsive to people’s needs? (for example, to feedback?)

The outpatients department provided clinics across a range of clinical specialities at the hospital and from a number of sites across the Greater Manchester area. This enabled patients to access a broad range of services depending on their needs.

Patients received information about their appointments by post. Staff were able to rearrange the appointment date if a patient asked them to. A review of appointment attendance data showed that approximately 11.47% of patients did not attend their appointments, against a trust target of 10% or less. The department reduced the number of patients who did not attend appointments by implementing an appointment reminder system.

The Lead Nurse for Support Services told us they reviewed data for patients who did not attend appointments. Where patients were identified as having a learning disability, staff contacted them to identify why they were unable to attend their appointments and to arrange further appointments if needed.

The department sought feedback from patients through patient experience surveys. The surveys were given to patients in the waiting areas. The feedback was collated on a monthly basis by the Risk and Governance Manager based on at least 20 responses from seven specialty areas. During September 2013 there were 149 responses. The responses were displayed as charts on a notice board in each area. The survey covered key areas such as staff courtesy, waiting times, privacy, quality of care and cleanliness. The information was used to look for possible improvements to the service.

# Outpatients

## Are outpatients services well-led?

There was an effective clinical governance system in place that allowed risks to be escalated to divisional and trust Board level through various committees. Staff meetings took place monthly to discuss concerns and to share information. Staff carried out monitoring of key processes, including aseptic non-touch technique, patient delays, equipment decontamination, hand hygiene and infection control. The department also had an outpatient assessment and accreditation system based on the trusts' objective to provide safe, clean and personal care every time.

The outpatients department had clearly defined leadership roles. The Nurse Manager oversaw the nursing and support staff. The Nurse Manager reported to the Lead Nurse for Support Services. The department had staff with specific lead roles, such as a safeguarding lead and an infection control lead.

Staff were positive about the support they received from the management team. Staff said they were supported with additional learning and continuing professional development. This ensured that staff were properly trained and supervised to care for patients. Training data showed that the majority of staff had completed their mandatory training and annual appraisals.

# Good practice and areas for improvement

## Areas of good practice

- Our inspection team highlighted the following areas of good practice:
- The Bereavement Centre (also known as the Pam Wood Suite) provided a service to bereaved families and friends efficiently and with great sensitivity. The staff at the bereavement centre also provided a service to staff who may be affected by death. The praise given to this centre on our visit was exceptional. Everybody we spoke to felt that this service was outstanding, as it supported the whole hospital and the attitude and compassion shown by the staff were exceptional.
- The EPR (electronic patient records) system was extremely well used in all areas (apart from A&E) and provided for a largely paperless organisation. Staff at all levels appreciated this, and it meant that a patient could move seamlessly through the organisation and their medical history was easily available wherever they went.
- The trust demonstrated exceptional leadership qualities at all levels across the staff groups. The engagement and leadership of the non-executive directors and the governing council were outstanding. This supported a learning culture where everyone was encouraged and able to contribute. The trust said it was proud to enable a learning culture rather than a blame culture. It felt this allowed staff to be responsible for their own mistakes and to learn from them.
- The trust strives to be the best hospital in the country and has worked hard to embed this among every member of staff. It has key values of 'Safe, Clean, Personal' which were demonstrated at all levels and throughout everything it does, and were clearly meaningful to all staff. This message was evident in practice in wards known as SCAPE wards. (Safe, Clean and Personal Every Time). Every member of staff we spoke to could describe to us what SCAPE meant to them and how it improved the quality of the experience for the patient. Every member of staff wanted to be associated with a ward that had achieved SCAPE status. The award of SCAPE status was highly valued by all staff. It was clear recognition of a high quality and high performing ward which put safety, cleanliness and personalisation for patients at the top of its priorities. The award could be taken away if the quality was not maintained. This meant staff wanted to continually achieve and keep this status for the benefit of patients.
- The trust had systems on its wards for being totally transparent about staffing levels. Patients, visitors and other staff therefore could see quite clearly if staffing levels were being maintained.
- As part of the quality improvement agenda, the trust has set up a junior doctor support group called Trainees Improving Care through Leadership and Education (TICKLE). This enabled trainee doctors doing part of their training at the trust to contribute effectively to patient safety and quality improvement work. This level of engagement with junior doctors was excellent and commented on positively by junior doctors in the focus groups held.
- Safety 'huddles' were a routine part of handover practice across the trust and allowed efficient transfer of information between shifts. These took place twice daily to ensure that everyone had up-to-date information.
- A&E had recently created the post of transfer co-ordinator to help move patients from the department, once a bed was available in the hospital. This post was proving to be successful in ensuring that patients received a smooth transfer between departments.
- Over the previous 12 months, the trust had significantly reduced the incidence of patients having surgery cancelled on the day by having an effective pre-assessment process.
- The trust had significantly reduced the number of falls on the frail elderly ward by providing one-to-one care for patients at risk. The number of falls was below the national average. This is a remarkable achievement.
- The trust provided systems for all patients, relatives and staff to be aware of the planned staffing level and the actual staffing level for each ward. This showed an openness and transparency from the trust, and a willingness to be challenged around the sufficient staffing provisions.
- The trust worked well with external stakeholders such as GPs to improve the quality of the healthcare within the hospital. For example, staff at the trust could book appointments with local GPs for patients. This was part of a "deflection" programme set up with the local GPs to try and reduce waiting times in A&E and provide an improved service to patients if their local GP was better

# Good practice and areas for improvement

suited to treating their condition. In addition, patients who left A&E before being seen were contacted by hospital staff to see if they still needed assistance, and advice was offered as necessary.

## Areas in need of improvement

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

- There were some minor issues with the paper-based patient records system in A&E. However, these will be addressed with the adoption of the electronic patient records system in January 2014. The inspection team acknowledged that the paper-based system had no detrimental impact on patient care. After our announced visit, we were told that the trust had carried out a detailed audit of its systems and had provided further assurance that its systems were safe and effective.
- Although policies and procedures were in place, in a small number of areas (A&E and children's care) some departmental policies were outdated. Up-to-date policies ensure that staff are aware of current procedural guidance within the trust. We raised this with the trust during our visit, and it addressed the issue immediately. This had not affected patient care.