The Pennine Acute Hospitals NHS Trust

The Royal Oldham Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

We carried out an announced inspection of The Royal Oldham Hospital between 23 February to 3 March 2016 as part of our comprehensive inspection of The Pennine Acute Trust.

Overall, we rated he Royal Oldham Hospital as Inadequate. Improvements were needed to ensure that all services were safe, effective, caring, well led and responsive to people's needs. Of particular concern were maternity services, services for children and young people and critical care services. We have rated these services as inadequate overall, with a rating of inadequate given for the safe and well-led domains. We also rated urgent and emergency services inadequate for responsive due to concerns in relation to access and flow within the service.

Our key findings were as follows:

Incident reporting

- An independent review into nine serious incidents in the maternity services at the trust had been completed in January 2015. Following this several recommendations were made about incident reporting. These included; clarifying the process for escalating concerns, a quality check for incident reports to ensure the root cause was clearly established, making recommendations clear and unambiguous and where individual failings had been identified, including leadership failings, reports must demonstrate education and training had been considered. These recommendations had not been put into practice in the management of incidents we reviewed. We saw reports with no recommendations or learning points recorded, staff, including senior managers, were unaware of the outcomes of serious incident investigations and the process for quality checking of reports was not understood by those completing investigations.
- In the past 12 months the trust had reported 32 serious incidents in maternity services. 21 of these had been reported retrospectively as the need to do so had not been identified through previous review.
- There was a delay in the management of incidents in the maternity services. Information provided by the trust showed as of 21 February 2016 there were 170 unclosed incidents in maternity and gynaecology services. Failure in the management of incidents was on the trust maternity and gynaecology risk register. This was a failure "to ensure monitoring that serious incident recommendations were appropriately incorporated and executed in actions plans leading to a failure to learn lessons and prevent avoidable harm". One of the actions to monitor this was "regular auditing of the process" which had a target date of 31 January 2016. At the time of the inspection no audits had taken place.
- In children and young people's services there were unacceptable delays in the investigation of serious incidents. Learning from incidents was not effectively shared resulting in serious incidents with similar causal factors recurring. Action plans following serious incidents were not followed up on resulting in identified actions not been addressed and learning from incidents not being effectively embedded.
- The trust board relied on incident reporting as an assurance mechanism regarding patient safety. However, nursing staff in children's services told us that incidents were not always reported. During our inspection we observed three incidents that were not reported. Senior nursing staff were aware that staff did not report all incidents.

However:

Summary of findings

- In all other core services we inspected, Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the clinical matron or lead consultant.
- Incident reports showed that duty of candour guidelines had been applied where serious harm had occurred. This included a formal apology to the patient and their relatives along with an explanation of the remedial steps to be taken to address the issue.
- If the SPCT noted a high rate of EOL related incidents on a particular ward they would develop a ward based programme to address identified issues. They reported that this approach had been successful in reducing incidents on targeted wards.

Cleanliness and infection control

- All areas we inspected were visibly clean, tidy and maintained to a good standard. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- Staff told us all patients admitted to the hospital were screened for MRSA. Patients identified with diarrhoea and vomiting symptoms were also screened for C.difficile. Patients with recent hospital admissions were also screened for Carbapenemase-producing Enterobacteriaceae (CPE) infections.
- Services undertook regular audits to monitor compliance against key trust infection control policies such as hand hygiene, use of PPE, isolation precautions.
- The surgery and anaesthesia division at Oldham reported similar or lower surgical site infection (SSI) rates across all specialities compared to the England average for the last 5 years. However, infections in colorectal operations were slightly higher than the England average.
- The most recently supplied ICNARC data for the HDU (July to September 2015) showed no cases of unit acquired infections with Methicillin resistant staphylococcus aureus (MRSA) and small numbers of unit acquired Clostridium difficile (C diff). Infection rates were generally better than comparable units.
- For the same period on the ITU at Royal Oldham, in terms of unit acquired infections in blood for ventilated admissions, performance was comparable with similar units. For elective surgical admissions there were no cases of unit acquired infections in blood. For emergency surgical admissions the last reported case of a unit acquired infection in blood was in quarter one of 2014. Unit acquired MRSA and C diff infection rates were better than comparable units and no cases of MRSA bacteraemia had been reported.

However

- In medical care services cleaning chemicals were left out in an unlocked room on a number of wards and there were trolleys containing sharp instruments which were not locked away and had been left unattended.
- Following higher than national incidences of puerperal sepsis in 2013 an action plan had been developed to ensure the rates were reduced. Aseptic non touch technique training was part of this plan. Information from the trust showed 75% of nursing and midwifery staff and 37% of staff in additional clinical services were up to date with this training. This meant not all staff who delivered care were up to date with this training. The trust was not compliant with this action they had identified to prevent puerperal sepsis.

Summary of findings

- On the paediatric and neonatal ward, we found no equipment cleaning logs completed. Nursing staff told us that the expectation was that they cleaned the equipment then returned it to the equipment area. This was not in accordance with the trust's policy. Similarly, cleaning schedules for paediatric and neonatal areas were not available.

Nursing staffing

- There were a number of departments in the hospital where there were concerns regarding nurse staffing.This was particularly significant within the critical care, maternity and gynaecology and children and young peoples services
- We saw that the average sickness rate and staff turnover rate in a number of departments was above the trust target of 4%
- In urgent and emergency care services the nursing and healthcare support worker staffing levels and skill mix was not sufficient to meet patients' needs. The existing establishment did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. An independent nurse staffing review in November 2015 recommended an increase to the current establishment by 15.80 whole time equivalent staff in order to fully meet safe staffing standards.
- At the end of November 2015 the vacancy rate for nursing staff in medical services trust-wide was 7% and this was recorded on the risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme. Managers knew where there were shortfalls and where there was surplus on other wards so that staff that could be called on if needed and vacancies were being covered by using agency or bank staff.
- In surgery, staffing figures for January 2016 showed some areas had on occasion only 85% of their allocated establishment of registered nurses on duty during the day. Gaps in the rota were filled with hospital bank shifts and external agency staff. There was high use of agency staff in theatres but even with these staff, staffing establishments were not always maintained.
- The nurse staffing on both the ITU and HDU failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7. This issue was well known to the trust and was highlighted as a concern in the May 2015 review by the GMCCN.
- Despite the ITU and HDU units not meeting the standard for nursing cover, they were often asked to supply staff to assist the other critical care areas within the trust.
- Along with the other critical care units in the trust, the nursing budget was subject to a £140,000 cost improvement plan for the coming year.
- Nurse staffing levels and skills mix in paediatrics did not reflect Royal College of Nursing (RCN) guidance (August 2013). There were no advanced paediatric life support (APLS) or European paediatric life support (EPLS) trained nursing staff. Only 23.7% of nursing staff were up to date with paediatric immediate life support training.
- We reviewed neonatal staffing in line with BAPM (British Association of Perinatal Medicine) guidance over the course of a month. In 25.8% of shifts, nurse staffing did not comply with BAPM guidance for the nurse: patient ratio. On average in each of these shifts the unit was understaffed by at least one registered nurse. When we reviewed the planned vs actual staffing information, this showed in 83.3% of shifts the unit was understaffed by on average 2.2 nurses.
- Neonatal records showed that only 23.9% of nursing staff had current NLS training at the time of our inspection.
- The trust did not routinely use an acuity tool, as recommended by RCN guidance, at the time of our inspection. However, in December 2015 the trust trialled an acuity tool for one week (19 shifts). At the time of our inspection no plans were in place to introduce an acuity tool.
- There were insufficient staffing levels to meet the needs of EOL patients with complex care needs at the current levels. There was a trust wide EOLC facilitation team which was based at ROH. This team provided specialist training in the treatment and management for patients approaching the end of their lives. They had provided the training for the IPOC implementation. The actual staffing for this team were below the planned level. This staffing deficit impacted on the team's ability to roll out the transformation programme and embed the use of Individual Plan of Care (IPOC) across all ROH wards.

Summary of findings

However:

- Nursing staffing levels in outpatients were in line with planned numbers, there was a good staff skill mix and the trust had clear escalation procedures in place where safe staffing levels in clinics could not be established. There were few vacancies in pathology, except in Cytology.

Midwifery staffing

- The midwifery staff to patient ratio was worse than the England average and the labour ward frequently had lower than the planned number of midwives working. Midwives were not achieving one to one care in labour. Midwife sickness levels were high. Whilst there were some delays in patient care due to low staff numbers these were limited due to staff of all grades working extra hours and through their breaks to support patients.
- All the midwives and managers we spoke with stated staffing issues were their major concern for the maternity services. This had been recognised by the trust and the "failure to achieve safe staffing levels" was on the risk register. Managers used the red flag system to raise concerns about specific staffing levels. These were documented on the four hourly staffing assessment documentation for all wards. This met the safer staffing guidance.
- During our inspection staff had requested to divert patients from the labour ward one night due to there being seven midwives instead of nine, the unit was full and a high level of care was provided to a deteriorating patient. Additionally both obstetric theatres had been used. All avenues to increase the staff numbers had proved unsuccessful. This divert was not approved by the on call manager instead they tried to provide a specialist high dependency nurse to the unit but were unsuccessful. Midwives had escalated their concerns that this was unsafe to the manager on call. Following our inspection implementation of the escalation policy was reviewed and assurances given that it would be used proactively when activity on the wards was assessed every four hours or between if necessary.

Medical and surgical staffing

There were a number of departments in the hospital where there were concerns regarding medical staffing. This was particularly significant within the critical care, maternity and gynaecology and children and young peoples services

- There were medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme.
- The HDU was not led by the intensivist/anaesthetists. It was not clinically led by any designated consultant. It was an open unit with potential referral and admissions from any speciality within the hospital. Consequently this meant that on the HDU many of the standards for critical care as set out in the "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care and the Guidelines for the Provision of Intensive Care Services (GPICS) Standards.(2015) were not being met.
- Out of hours cover also varied between the ITU and HDU. For the ITU there was always a consultant on call. The HDU relied upon the on call doctors from the respective parent teams.
- Information from the trust showed that there had been 135 hours of consultant cover on the labour ward to June 2015. In the past 12 months there had been 5219 births which meant they should have 168 hours cover to meet the 2010 Royal college of Obstetrics and Gynaecology guidelines. Following our inspection, the trust confirmed they would review the consultant workforce to provide more consultant cover at the Oldham site. This would be fully implemented in August 2016.
- Doctors told us they were concerned about gaps in the consultant resident on call rota on Friday evenings. There was a twilight shift 5pm to 8.30pm from Monday to Thursday; however there was no resident cover for this shift on a Friday which meant there was no resident on call between 5pm Friday and 8am Monday. A consultant was on call from home and two middle grade doctors provided resident cover. Following the inspection the trust confirmed this shift would be covered as a matter of urgency.

Summary of findings

- Facing the Future Standards recommend there should be consultant presence on the ward at self-defined peak times. Hospital staff told us that their peak times were between 4pm and 9pm. The hospital had consultants scheduled to be on site up until 5pm. We raised this issue with the trust. They confirmed that consultant presence during peak times was not in place. The trust advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.
- Facing the Future Standards recommend that every child who presents with an acute medical problem is seen by a consultant, or equivalent, within 24 hours. In one paediatric serious incident investigation we reviewed this had not occurred and was deemed a causal factor in the delay of diagnosis. The trust did not monitor this standard at the time of our inspection.
- There was no specialist consultant cover at ROH for palliative care.

However:

- The ITU was a closed unit, clinically led by intensivist/anaesthetists who were able to gate keep the admissions and discharges. With input from the parent teams as appropriate the clinical care was directed and delivered by the intensivist/anaesthetists.
- There were no gaps at consultant level in outpatients.
- The emergency department had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients received the right level of care.
- Rotas were completed for all medical staff which included out of hours cover for medical admissions and all medical inpatients across all wards. Medical trainees contributed to this rota. The information we reviewed showed medical staffing was appropriate at the time of the inspection.
- Existing vacancies and shortfalls in surgery were covered by locum, bank or agency staff when required, such staff were provided with local inductions to ensure they understood the hospital's policies and procedures.

Access and flow

- Between April 2015 and February 2016, the emergency department consistently failed to meet the Department of Health (DH) target to admit, transfer or discharge 95% of patients within four hours of arrival.
- The average time to treatment in A&E was consistently worse than the 60 minute DH standard between August 2015 and February 2016. The average total time spent in the emergency department by admitted and non-admitted patients was also higher than the England average during this period.
- The percentage of emergency admissions waiting between four and 12 hours to be admitted was similar to the England average between August 2014 and June 2015, rising above the average during July 2015 to August 2015.
- The department failed to meet the DH guidelines relating to trolley waits as nine incidents were reported where patients had trolley waits of more than 12 hours between November 2015 and February 2016. This included five breaches reported during February 2016 indicating a worsening trend. There were no reported 12-hour trolley breaches in the department between February 2015 and October 2015.
- The emergency department had historically recorded the decision to admit (DTA) time as decision at the point of referral to speciality. Since February 2016, the department was trialling a process where the DTA time was recorded at the point when the decision to admit was made by the emergency department clinician. The change in reporting DTA processes could account for the increased number of 12-hour trolley wait breaches reported by the department.
- The percentage of patients triaged within 15 minutes averaged 85.7% between February 2015 and September 2015. However, the average between October 2015 and January 2016 indicated a worsening trend in performance.
- The DH target is that handovers between ambulance and emergency department staff must take place within 15 minutes with no patients waiting more than 30 minutes. The department did not meet this target between April 2015 and January 2016. The data showed there was a rising trend as 70% of delayed handovers took place between October 2015 and January 2016.
- There were 468 'black breaches' reported by the department between April 2015 and January 2016. Records showed 357 (76%) of these took place in the most recent three months between November 2015 and January 2016.

Summary of findings

- The proportion of patients leaving the department without being seen was within the DH target of 5% but higher (worse) than the England average between February 2015 and January 2016.
- Between October 2015 and December 2015, the average occupancy rate at the hospital was 98%. Research has shown that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Between January 2014 and December 2014 hospital episode data (HES) showed the average length of stay for elective medicine at the hospital was worse than the England average. For non-elective medicine it was better than the England average.
- In medical care services, information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs.
- There was a high number of patients who were moved between wards during the night on the acute medical ward and just under half of the patients experienced one or more moves during their stay.
- There were occasions when people had to stay in the discharge lounge overnight and we saw that a patient had not had a regular review by a doctor whilst on the discharge inpatient unit.
- Between July 2014 and June 2015 hospital episode data (HES) showed the average length of stay for elective surgery overall at the hospital was marginally worse than the England average. For elective colorectal surgery, the average length of stay was worse than the England average. However for elective vascular surgery and elective trauma and orthopaedic surgery length of stay was better than the England average.
- For the same period the average length of stay non-elective surgery was marginally worse than the England average. For non-elective trauma and orthopaedic surgery and vascular surgery length of stay was much better than the England average. However, for general surgery the average length of stay worse than the England average.
- Trust wide from January 2015 to December 2015 895 were cancelled for non-clinical reasons, of those 10 were not treated within 28 days. This was much better than the average rate across England.
- The readmission rate for surgical patients with 28 days of discharge was much worse than the England average.
- The British Orthopaedic Association 'standards for trauma' (BOAST) recommend that patients with a fractured neck of femur should have reparative surgery within 36 hours of presentation. From April 2015 to January 2016, Oldham met this target in 64.3% of patients on average across those months. This meant that one in three patients failed to have their surgery within the recommended timeframe. This breach of standards is associated with increases the mortality and morbidity outcomes in such patients.
- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from critical care there was often a delay in discharge.
- The figures for April 2014 to March 2015 showed that 36% of patients on the level 3 ITU experienced a delayed discharge and 52% of patients on the level 2 HDU had their discharge delayed. The majority of the delays were between one and three days with the occasional patient waiting as long as a week.
- In terms of out of hours discharges the ITU was performing much better than comparable units whereas in the HDU, the ICNARC data for July to September 2015 showed that 23% of the discharges occurred out of hours.
- As a consequence of access and flow issues within the hospital, during the 12 months from December 2014 to December 2015, 16 patients had been ventilated outside the critical care unit.
- The average length of stay on maternity wards was longer than the trusts' target with delays in discharges from the postnatal ward, especially out of hours.
- In outpatient and diagnostic services, the percentage of people waiting more than six weeks for a diagnostic test had been worse than the England average since July 2015.
- Though it was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average and the cancer waiting times for the trust were consistently better than the England average, we have subsequently learned that data collection in the department is not reliable and are not assured that targets are truly at that level. Work is being undertaken with the trust to clarify the current position.

Summary of findings

- The numbers of patients failing to attend their appointments was worse than the England average and there were no clear plans in place to improve this situation.

However:

- The hospital met the national target time of 18 weeks between referral and treatment for 95.6% of their patients.
- Hospital bed management meetings were held regularly throughout the day to review and plan patient capacity. We saw that staff were able to review and respond to acute bed availability pressures.
- The CYP service achieved the national referral to treatment target between April and November 2015 within the paediatric specialities.
- Bed occupancy in maternity services was lower than the England average. The referral to treatment times and the waiting times for the cancer pathway in gynaecology were met.
- Rapid discharge processes were in place to ensure patients could be transferred to their preferred place of care in a timely manner.

Leadership and management

- In the main, staff reported that managers were approachable, visible and that they felt comfortable reporting difficult matters to them. Staff stated that they knew who the executive team and board members were and that they were visible and responsive.
- The emergency department at the hospital had clearly defined and visible local leadership. There was a lead consultant and clinical matron in place to manage the day-to-day running of the department. The nursing and medical staff told us they understood the reporting structures clearly and that they received good management support.
- In medical care services, all nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.
- There were clearly defined leadership roles across the surgery and anaesthesia division. Leadership of each clinical group was through a triumvirate arrangement, which was relatively new to the trust and division. Individual ward managers appeared enthusiastic, competent and hardworking and were well thought of amongst ward staff. Nursing staff told us they felt supported and that there were good working relationships within the teams.
- The work of the SPCT and EOLC was overseen by the EOLC steering group. This group was chaired by the lead consultant in palliative care. There was trust board involvement in the leadership of the service through the chief nurse and non-executive lead.
- The SPCT was managed by the Macmillan associate lead cancer/palliative care nurse. There was an operational policy in place for the SPCT which included clear statement of governance structures.
- It was not clear that the leadership of the service understood the challenges involved in establishing a pilot project for seven day working on current staffing levels

However:

- Within both critical care units, ITU and HDU there were designated nurse leaders. However, whilst there was a designated clinical lead for the level 3 ITU, there was no similarly designated clinical medical lead for the level 2 HDU facility. The arrangements for admission, discharge, on-going management and responsibility for patient care was different for the level 2 HDU at ROH than for the trust's other critical care areas, as detailed in the trust's critical care operational policy (version 5).
- There was a lack of visible midwifery leadership above ward level although this had improved at the unannounced inspection. There was low morale and a culture of blame in midwifery services.

Summary of findings

- There had been no clinical director in pathology services since October 2015. The clinical lead in cellular pathology had also left and the service manager had no one to report to at the time of inspection. Recruitment for the posts was underway.

We saw several areas of outstanding practice including:

Importantly, the trust must:

Action the hospital MUST take to improve

Urgent and Emergency Services

- Ensure that patients attending the department are assessed and treated in a timely manner.
- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the Urgent and Emergency department

Medical services

- Ensure that records are kept secure at all times so that they are only accessed by authorised people.
- Ensure that all staff are aware of the procedures for capacity assessments and these are completed where necessary
- Ensure that systems in place to manage controlled drugs are robust especially in the acute medical unit
- Ensure that assessments of patient's nutrition and hydration needs are fully completed and patient's receive appropriate support where necessary
- Ensure that patients are discharged as soon as they are fit to do so.
- Ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.

Surgical Services

- Ensure that the recording and disposal of controlled drugs where the whole of one vial is not prescribed, is in line with trust and Royal Pharmaceutical Society of Great Britain guidance.
- Ensure that there are sufficient nursing staff on duty to keep patients safe at all times, by working towards filling vacancies and reducing sickness.
- Ensure that were there is cause to question a patient's capacity, that this is documented fully in the patient's record; detailing how and why it has been determined that the person has or does not have capacity and that subsequent documentation which is generated based on that decision such as consent 4 documents or DNACPR are completed accordingly.
- Ensure that DNACPRs are reviewed regularly particularly when a patient's condition and prospects have changed dramatically since the decision was made.

Critical care

- Take action to ensure that level 2 patients on the high dependency unit at the Royal Oldham Hospital are managed in accordance with the national guidance and standards for critical care.
- Take action to reduce the numbers of delayed and out of hours discharges from both level 2 and level 3 critical care facilities.

Maternity and Gyneacology Services

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the maternity services. This includes sufficient consultant resident cover in the labour ward.
- Assess the risks to the health and safety of patients of receiving the care or treatment.
- Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

- Investigate incidents within agree timescales and take action to prevent recurrence

Children and Young People

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the paediatric and neonatal services. This includes sufficient medical cover.
- Ensure consideration is given to maintaining children's dignity at all times.
- Assess the risks to the health and safety of patients of receiving the care or treatment.
- Ensure the investigation of incidents within agreed timescales and take action to prevent recurrence.
- Ensure that electrical equipment is appropriately maintained and fit for purpose.

End of life services

- Take action to ensure that any DNACPR decision is supported by the consent of the patient.
- Take action to ensure that where a patient appears to lack capacity to consent to a DNACPR decision, a mental capacity assessement must take place prior to the decision being taken.
- Take action to ensure where a patient has been assessed as lacking capacity to make the DNACPR decision a documented discussion with patient's family takes place prior to the decision being taken.
- Take action to recruit to the consultant in palliative medicine position that is currently vacant.

Outpatient and diagnostic services

- Take action to ensure that staff who work in the Elective Access department receive annual appraisals.

Action the hospital SHOULD take to improve

Urgent and Emergency Services

- Consider taking appropriate actions to improve the processes for reviewing and managing key risks to the services.
- Consider taking appropriate actions to improve the processes for monitoring and improving the management of sepsis.

Medical Services

- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.
- Consider the design of the resuscitation trolleys to ensure they are tamper proof
- Ensure that patient pain is consistently recorded
- Patients on the discharge unit are regularly reviewed where required
- Ensure that all staff seek consent for the use of bedrails and if they lack capacity apply the Mental Capacity Act (2005) principals and this is reflected in procedures

Surgical Services

- Embed a recognised early warning system which gives clear and unambiguous guidance on escalation procedures and care for the deteriorating patient.
- Ensure compliance with all elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients.
- Ensure that they take steps to improve compliance with the recommendations of the British Orthopaedic Association standards for Trauma (BOAST) to prevent patients waiting longer than 72 hours before seeing an orthopaedic specialist.
- Ensure that they take steps to improve compliance with the recommendations of the British Orthopaedic Association standards for Trauma (BOAST) to prevent patients waiting longer than 36 hours before surgery for fractured neck of femur and improve compliance with the hip fracture audit best practice tariffs.

Summary of findings

- Ensure steps are taken to address their very high readmission rates.
- Ensure they work towards compliance with all of the recommendations of the Faculty of Pain Medicine's Core Standards for Pain Management (2015).

Critical care

- Consider that care within the level 2 critical care unit is clinically led by a consultant in intensive care medicine.
- Consider that there is a supernumerary band 6/7 shift co-ordinator on duty 24/7.
- Consider that there are standard protocols in place for the administration of intra-venous infusions on the level 2 high dependency unit.
- Consider that the critical care risks on the risk register are regularly reviewed and updated with actions.
- Consider that the existing arrangement for the servicing and repair of equipment assures them that all critical care equipment is fit for purpose.
- Consider how it can embed training on Duty of Candour to all staff.
- Consider how it can develop and expand the critical care outreach service to provide cover 24/7.
- Consider how it is going to embed the delirium strategy into the day to day care of patients receiving critical care.
- Consider how it is going to meet the intensive care society standards for the provision of pharmacy and allied health professional support to the critical care service.

Maternity and Gyneacology Services

- Consider including actions and sharing lessons learned following the mortality or morbidity meetings to use them to improve practice.
- Consider having a system to provide feedback, develop actions and share learnings from complaints.
- Consider how the actions from the maternity improvement plan will continue to be implemented.
- Consider continuing the actions identified in the action plan of 2013 to prevent puerperal sepsis.
- Consider introducing a system to check the completion of fluid intake and output charts.
- Consider implementing an access and exit system on the post natal ward which protects patients.
- Consider keeping staff mandatory training and that specific to the role they completed up to date at all times.
- Consider a safety message being delivered at handover
- Consider multidisciplinary handovers on the labour ward.
- Consider introducing mechanisms to reduce the delays in induction of labour.
- Consider how gynaecology patients can receive results following diagnostic procedures in a timely way.
- Consider implementing actions from audits.
- Consider how the information on the maternity dashboard can be used to inform and improve practice.
- Consider making sure all staff appraisals are up to date.
- Consider how risks are managed.
- Consider improving the engagement with staff and the public.

Children and Young People

- Consider including actions and sharing lessons learned following the mortality or morbidity meetings to use them to improve practice.
- Consider deploying at least two trained members of staff to work in the observation and assessment unit.
- Consider keeping staff mandatory training and that specific to the role they completed up to date at all times.
- Consider nursing staff presence at morbidity and mortality meetings.
- Consider how the hospital is going to meet the facing the future standards
- Consider implementing actions from audits.
- Consider how the information on the paediatric and neonatal dashboards can be used to inform and improve practice.
- Consider making sure all staff appraisals are up to date.

Summary of findings

- Consider how risks are managed.
- Consider improving the engagement with staff and the public.

End of Life

- Ensure that DNACPR documentation is completed in accordance with its own trust policy.
- Consider how it can embed training on Duty of Candour to all staff.
- Consider how it can develop and expand the critical care outreach service to provide cover 24/7.
- Consider how it is going to embed the delirium strategy into the day to day care of patients receiving critical care.
- Consider how it is going to meet the intensive care society standards for the provision of pharmacy and allied health professional support to the critical care service.
- Consider a full review of the staffing requirements to introduce seven day specialist palliative care services at the hospital.
- Consider how to respond to the complex symptom control needs of EOL patients out of hours.
- Consider how to provide training to middle grade doctors about the complex symptom control needs of EOL patients.
- Consider whether the current SPCT staffing levels are sufficient to meet the current demands on the service.
- Consider how to involve SPCT in the service developments required to implement the EOL strategy.
- Consider the level of support and education required from EOLC facilitation team for FGH to embed the use of the IPOC documentation across all its wards.
- Consider how to develop a sensitive tool to ascertain when incidents occur related to EOL issues.

Outpatients and diagnostics

- The trust should consider changing the way that patient records are being scanned onto the EVOLVE system so that historic records are prepped and scanned on demand in advance of patient attendance at an outpatient clinic. This system has been seen working well in other trusts and ensures that “active” patient notes are prioritised.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Requires improvement

Why have we given this rating?

We judged urgent and emergency services as requires improvement overall because:

- Patients attending the department experienced extended delays before they received treatment. The emergency department consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.38% during this period.
- The average time to treatment was consistently worse than the 60 minute DH standard between August 2015 and February 2016. The total time patients spent in the department was also higher than the England average during this period. There were nine instances where patients had trolley waits of more than 12 hours in the three months between November 2015 and February 2016.
- The department failed to achieve the target for ambulance handover within 15 minutes between April 2015 and January 2016. There were 851 handovers that took between 30 and 60 minutes during this period. There were 468 ambulance handovers that took longer than 60 minutes (black breaches) reported by the department between April 2015 and January 2016.
- The percentage of patients triaged within 15 minutes averaged 85.7% between February 2015 and September 2015. However, the average between October 2015 and January 2016 was 77.9%, indicating a decline in performance. The proportion of patients leaving the department without being seen was within the DH target of 5% but worse than the England average between February 2015 and January 2016. Complaints were not routinely resolved within the trusts specified timelines.
- The emergency department had sufficient numbers of medical staff. However, there were vacancies in the nursing and healthcare support

Summary of findings

worker establishment, which meant the staff did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. An independent nurse staffing review took place during November 2015 and this recommended an increase to the current establishment by 15.80 whole time equivalent staff in order to fully meet safe staffing standards.

- The main reasons for delays in admission was due to insufficient bed capacity across the hospital, which meant patients that required admission could not be transferred to the wards in a timely manner. An urgent care improvement plan was in place to improve patient flow but key actions listed in the improvement plan were not scheduled for completion until August 2016.
- The urgent care directorate was formed recently and the clinical director and lead nurse for urgent care services across the trust had only been in post since December 2015 and January 2016 respectively. There was no formal strategy specifically for the service. The clinical governance system allowed key risks to be escalated and reviewed. However, the length of time taken to respond to these risks meant the department did not have a proactive approach to managing these risks.

However:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.
- Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits and performed in line with other hospitals and the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a

multidisciplinary team. Mandatory training compliance in the department was 90% and the trusts expected standard of 90% compliance had been achieved.
- There was effective local leadership and staff spoke positively about the they support received. Patients spoke positively about their care and treatment.

Medical care (including older people's care)

Requires improvement

We judged medical care services as requires improvement overall because:

- There were standards for record keeping that required improvement we found records were left unsecured on the acute medical unit and there was a risk personal information was available to members of the public.
- Resuscitation equipment was not always being checked and equipment could be accessed even though tamper seals were in place. There were a number of pieces of electrical equipment which had out of date safety certificates and oxygen was not being stored in line with guidance.
- There had been incidents of missing medication on the acute medical unit and training levels in medicines management was low .
- Staffing levels were largely adequate to meet the needs of patients but there were occasions on wards when there had been a reliance on agency or bank nurses as well as locum doctors.
- Staff were not always following trust policies and procedures in relation to assessing patients for capacity to provide informed consent and the completion of capacity assessments.
- There was insufficient bed capacity on occasions to meet the needs of people within the hospital . Some patients had to stay in hospital longer than was needed due to care packages not being in place when they were ready for discharge.
- Patients were not always supported with hydration and nutrition
- We saw staff interactions with people were person-centred; but there was limited interaction with patients on ward F10 and the acute medical unit out of the three ward areas visited.

Summary of findings

- It was unclear if learning was shared wider across other service areas and there were times when complaints took a long time to resolve

However:

- There were systems in place to protect people from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse.
- Incidents were reported by staff through effective systems and lessons were learnt and investigation findings and improvements made were fed back to staff at a local level.
- The hospital was visibly clean and staff followed good hygiene practices.
- Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a leaf symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs.
- All staff knew the trust vision and behavioural framework and said they felt supported and that morale was good.

Surgery

Requires improvement

We judged surgery as requiring improvement overall because:

- Staffing levels were low at times. There was a high nurse staffing vacancy rate and high levels of sickness. This meant that on occasions staffing was only 85% of the required level.
- The early warning system the hospital had adopted was implemented inconsistently and clear procedures for escalate concerns for a deteriorating patient were not embedded.
- The division did not correctly undertake assessments of mental capacity and consent to treatment in all cases.

Summary of findings

- The service was non-compliant with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients.
- The service had very high readmission rates, which were significantly higher (worse) than the England average.

However

- There was a good culture of reporting incidents and safety issues and investigations were thorough. We saw evidence of learning when things went wrong .
- The environment was clean and hygienic with low levels of healthcare associated infections.
- Care was planned and delivered in line with evidence based guidance and best practice. Patient outcomes were good and in some areas the division performed better than other trusts and England averages.
- Multidisciplinary team working was good with satisfactory access to a range of specialities. Staff were experienced and competent and had the skills to undertake their job effectively.
- Staff went about their work with a caring and compassionate nature. They protected their privacy and dignity of their patients when providing care and treatment.
- There was attention to individual patient needs and support for those with complex needs. The ward environment was very good for dementia patients and there was implementation of many of the recommendations from dementia best practice guidance.
- The surgery and anaesthesia division was well led both on a ward level and at divisional level.

Critical care

Inadequate

We judged critical care as inadequate overall because:

- There was no designated clinical medical lead for the level 2 HDU unit. As a consequence of this lack of leadership there were significant shortfalls where the national service specification for critical care (D16) and the GPICS standards were not being met on that unit.

Summary of findings

- The nurse staffing on both the ITU and HDU failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7.
- There was a critical care outreach team but this did not cover all of the wards and was not delivered 24/7.
- The hospital was non-compliant with a number of elements of the NICE clinical guidance around the rehabilitation of critically ill patients.
- There was a problem with delayed (both units) and out of hours discharges (HDU). The ICNARC data for July to September 2015 showed that 23% of the discharges from HDU occurred out of hours.
- It was not clear how risks to critical care were being managed. The risk register reported risks that had been identified for a number of years but there was a lack of clarity about mitigating actions, progress and review.

However:

- The units both contributed data to the intensive care national audit and research database (ICNARC). The most recent data showed that mortality rates for both level 2 and 3 areas was in accordance with comparable units.
- Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect.

Maternity and gynaecology

Inadequate

We rated maternity and gynaecology services as inadequate because:

- There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm. There was a failure to effectively investigate and learn from incidents with a lack of openness about outcomes.
- There was a lack of learning from complaints and a lack of learning and sharing of knowledge from discussions about mortality and morbidity.
- There was a shortage of midwifery staff which led to some delays in transfers during labour and inductions of labour.

Summary of findings

- There was a lack of actions to make identified improvements in audits of the quality of service provided had taken place.
- The security system on the post natal ward did not offer sufficient protection from abduction of babies.
- Midwives and medical staff were not up to date with training and competence for some of the tasks they performed. Most staff were not up to date with appraisals of their performance.
- There was a lack of clear systems and processes for managing risks and performance of the service.
- However:
- Some improvements had been made as a result of the maternity improvement plan including the purchase of necessary equipment.
- Midwifery and medical staff worked well as a team and provided compassionate care despite the shortage of staff.
- There was an enthusiasm amongst the staff to improve the services.
- Gynaecology procedures were provided on an outpatient basis and there was some innovation in this practice.

Services for children and young people

Inadequate

We ratedChildren and Young peopleservices as inadequate because:

- Risks were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate risks in the longer term.
- There were unacceptable delays in investigations including those resulting in severe harm.
- There was a failure to effectively investigate and learn from incidents. There was a lack of learning and sharing of knowledge from discussions about mortality and morbidity.
- Care and treatment did not always reflect current evidence-based guidance, standards and best practice. .
- Patients received care from staff that did not have the skills that are needed to deliver effective care. There were very low numbers of

Summary of findings

nursing staff who had current Paediatric Immediate Life Support (PILS) certification and none had Advanced Paediatric Life Support (APLS) certification. .

- In paediatrics we saw staff engaging with children and their parents kindly. However, patient's privacy and dignity were not always upheld.
- Staff told us there were times when they had to focus on the task they were undertaking rather than treating people as individuals to ensure that essential jobs were done e.g. provision of medications.
- Friends and family test results were poor, but parents and patients on the ward at the time of our inspection did not support the test's findings.
- We found that the needs of the local population were not fully understood when planning this service particularly when considering the number of under two's that would access the children's wards.
- There was no strategy within the service. The paediatric team were following the paediatric improvement plan, however there was no strategy for continuous improvement or sustaining changes resulting from it..
- Quality and safety were not a top priority for the trust board and decisions were taken that impacted on patient safety.

However

- On the neonatal unit staff interactions were positive and babies were treated with kindness and compassion.
- Parents felt supported and involved in the planning and decisions regarding their child's healthcare.

End of life care

Requires improvement

We rated End of life services as requires improvement because:

- There was no seven day service for SPCT out of hours and we identified three instances when patients suffered for longer than they should have.

Summary of findings

- Do not attempt resuscitation documentation (DNACPR) was not completed according to trust policy on a number of occasions, particularly with regards to patients who lacked capacity.
- The individual plan of care, which replaced the Liverpool care pathway, although developed, was not sufficiently embedded into all ROH wards
- There were depleted staffing levels of the SPCT at ROH and there were insufficient staff to implement a full range of services.
- There was a vacant post for the specialist consultant in palliative care.
- EOL patients were not always cared for in ward side rooms

However;

- There was a policy and procedure for reporting of incidents and all staff were aware of how to complete incident reports.
- There was evidence of anticipatory prescribing for pain and symptom control in medical notes.
- End of life services were caring. We observed staff delivering care with kindness, compassion and respect. Relatives told us that the care their loved ones received was excellent, that pain was monitored regularly and they were treated with dignity.
- There was a multi-faith spiritual care team, who were trained to provide non-religious support to those patients and relatives who were not religious.
- The SPCT had a good understanding of the needs of the local population, worked as part of the multidisciplinary team and had good links with palliative care services in the community.
- Religious and cultural requirements were adhered to when patients died and when they were transferred to the mortuary.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging services Good overall because:

- Staff were confident about raising incidents and encouraged to do so.

Summary of findings

- Principles of duty of candour when things went wrong were followed patients received an apology, full explanation and were supported going forward.
- The departments inspected were visibly clean and we observed staff following good practice guidance in relation to the control and prevention of infection.
- Equipment was clean and in good work order. Medicines were stored and checked appropriately.
- There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of their roles and responsibilities in regard to safeguarding.
- Staff in outpatients and diagnostic services demonstrated good team working (including multidisciplinary working) and were competent and well trained.
- Staffing levels were appropriate to meet patient needs
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff who treated people with dignity and respect.
- .The number of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average. The cancer waiting times for the trust were consistently better than the England average.

However,

- The trust reported in their missed cancer diagnoses action plan that they had produced a leaflet and banners to support and empower patients, to ask about the tests they have undergone and that these had been distributed in all sites in outpatients and radiology. During the inspection, we were unable to find the leaflets in clinics and staff had not heard about them.
- The paper notes we reviewed contained limited information, were out of sequence and in some cases were illegible also not all notes had been scanned and paper notes were still in use for some patients..

Summary of findings

- At November 2015 there was a staffing shortfall of 5.4wte Band 5 radiographers and 1wte Band 8a Manager. The department was actively recruiting 6 student radiographers
- We found there was no set of local rules and risk assessments to hand in a number of departments. They had not been printed off and signed by staff so there was no indication that they were aware of, and had an understanding, of the rules.
- Lucy Pugh Outpatients Department was located at the bottom of a very steep slope and was not safely accessible externally to those who were not steady on their feet or in the event of inclement weather. To enter the department internally via lift access involved a long walk through the hospital.

The Royal Oldham Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to The Royal Oldham Hospital

The Royal Oldham Hospital is in Oldham, a large town in Greater Manchester . The Royal Oldham Hospital is part of The Pennine Acute Hospitals NHS Trust. The Royal Oldham Hospital serves a population of approximately 230,000 people. There are approximately 445 inpatient beds on the site

The hospital hosts an Accident and Emergency department which treats approximately 97,500 patient a year, approximately 12,000 of these were children who are treated in a separate purpose built area . Medical care services at the hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology.

The surgical services at The Royal Oldham Hospital carry out a range of surgical procedures such as trauma and orthopaedics, urology, colorectal surgery, vascular surgery and general surgery (such as gastro-intestinal surgery).

The critical care services at the Royal Oldham Hospital provides care for up to eight level three (intensive care) patients and eight level two (high dependency) patients.

Maternity and gynaecology services provided at The Royal Oldham Hospital included offering pregnant women and their families antenatal, delivery and postnatal care. The department delivered approximately 5219 babies every year. A range of gynaecology services and termination of pregnancies was also provided. The paediatric and neonatal services that are at The Royal Oldham Hospital include a neonatal units which provides special care (19 cots) high dependency care(9 cots) and intensive care cots (9 cots). Other services for children and young people are provided in the children's ward which has 25 beds plus 2 high dependency beds

There is a specialist palliative care (SPC) multi-disciplinary team which is based at the Royal Oldham Hospital Patients with end of life care (EOLC) needs are cared for on the general wards at The Royal Oldham Hospital.

Outpatient services provided from The Royal Oldham Hospital are mainly held in two main departments . Diagnostic imaging services are provided at The Royal Oldham Hospital. MR scanning is provided by the trust radiology service at the Royal Oldham Hospital.

We inspected the hospital as part of the comprehensive inspection of The Pennine Acute Hospitals NHS Trust

Our inspection team

Our inspection team for the Trust was led by:

Detailed findings

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

Head of Hospital Inspections: Ann Ford, Care Quality Commission

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

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

The announced inspection of The Royal Oldham Hospital took between the 22 February and 3 March 2016. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants,, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We undertook an unannounced inspection between 4pm and 9.30pm on 17 March 2015. During the unannounced inspection we observed the care delivered in the medical department, staffing arrangements on the Childrens and neonatal ward We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Rochdale Infirmary.

Facts and data about The Royal Oldham Hospital

The Pennine Acute Hospitals trust provides general and specialist hospital services to around 820,000 residents across the north east of Greater Manchester in Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham, Rochdale and parts of East Lancashire.

In 2014/15 the hospital had 237,000 outpatient attendances and 97,716 patients attended the urgent care department from the communities.5219 babies were born at the hospital. In total the hospital has 445 beds.

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

Oldham is ranked 27th most deprived local authority (out of 326) and is in the most deprived quintile.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The urgent and emergency services at Oldham Hospital were provided 24 hours a day, seven days a week and provided urgent and emergency care and treatment for children and adults across Oldham, Greater Manchester and the surrounding areas.

The department had 97,716 attendances between November 2014 and November 2015 with an average weekly attendance of 1,879 during this period. 75% of patients attending the emergency department were adults and the remaining 25% were children up to 16 years of age.

The emergency department included separate triage and waiting areas for adults and children. There was a separate children's area with six cubicles. The resuscitation area could accommodate up to five patients and there was also a separate trauma bay for adults and children. The emergency department was a receiving centre for major trauma patients. The minor injuries area had nine cubicles and five consultation rooms. The major injuries area had 13 cubicles.

Patients that required diagnosis, observation, treatment and rehabilitation, including overnight stay, were transferred to the emergency department observation ward which had eight beds, split into two four-bedded male and female bays.

We visited the emergency department at The Royal Oldham Hospital during our announced inspection on 23-26 February 2016. We also carried out an unannounced inspection on 17 March 2016.

We spoke with seven patients, observed care and treatment and looked at the care records for six patients. We also spoke with a range of staff at different grades including nurses, doctors, consultants, the lead consultant, the practice educator nurse, a the mental health liaison nurse, the clinical matron, the clinical director for urgent care, the interim divisional director for urgent care and the lead nurse for urgent care. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

We judged urgent and emergency services as requires improvement overall because:

- Patients attending the department experienced extended delays before they received treatment. The emergency department consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.38% during this period.
- The average time to treatment was consistently worse than the 60 minute DH standard between August 2015 and February 2016. The total time patients spent in the department was also higher than the England average during this period. There were nine instances where patients had trolley waits of more than 12 hours in the three months between November 2015 and February 2016.
- The department failed to achieve the target for ambulance handover within 15 minutes between April 2015 and January 2016. There were 851 handovers that took between 30 and 60 minutes during this period. There were 468 ambulance handovers that took longer than 60 minutes (black breaches) reported by the department between April 2015 and January 2016.
- The percentage of patients triaged within 15 minutes averaged 85.7% between February 2015 and September 2015. However, the average between October 2015 and January 2016 was 77.9%, indicating a decline in performance. The proportion of patients leaving the department without being seen was within the DH target of 5% but worse than the England average between February 2015 and January 2016. Complaints were not routinely resolved within the trusts specified timelines.
- The emergency department had sufficient numbers of medical staff. However, there were vacancies in the nursing and healthcare support worker establishment, which meant the staff did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. An independent nurse staffing review took place during November 2015 and this recommended an increase to the current establishment by 15.80 whole time equivalent staff in order to fully meet safe staffing standards.
- The main reasons for delays in admission was due to insufficient bed capacity across the hospital, which meant patients that required admission could not be transferred to the wards in a timely manner. An urgent care improvement plan was in place to improve patient flow but key actions listed in the improvement plan were not scheduled for completion until August 2016.
- The urgent care directorate was formed recently and the clinical director and lead nurse for urgent care services across the trust had only been in post since December 2015 and January 2016 respectively. There was no formal strategy specifically for the service. The clinical governance system allowed key risks to be escalated and reviewed. However, the length of time taken to respond to these risks meant the department did not have a proactive approach to managing these risks.

However:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.
- Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits and performed in line with other hospitals and the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Mandatory training compliance in the department was 90% and the trusts expected standard of 90% compliance had been achieved.
- There was effective local leadership and staff spoke positively about the they support received. Patients spoke positively about their care and treatment.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated this service as requires improvement for safe because:

- The emergency department had sufficient numbers of medical staff. However, there were vacancies in the nursing and healthcare support worker establishment, which meant the staff did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods. This is in breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- An independent nurse staffing review took place during November 2015 and this recommended an increase to the current establishment by 15.80 whole time equivalent staff in order to fully meet safe staffing standards.
- The percentage of patients triaged within 15 minutes averaged 85.7% between February 2015 and September 2016. However, the average between October 2016 and January 2016 was 77.9%, indicating a worsening trend in performance.
- The department failed to achieve the target for ambulance handover within 15 minutes between April 2015 and January 2016. There were 851 handovers that took between 30 and 60 minutes during this period.
- There were 468 'black breaches' reported by the department between April 2015 and January 2016. Records showed 357 (76%) of these took place in the most recent three months between November 2015 and January 2016.

However:

- Overall mandatory training compliance in the department was 90% and the trusts expected standard of 90% compliance had been achieved.
- Patient safety was monitored and incidents were investigated to assist learning and improve care.
- Patients received care in safe, clean and suitably maintained premises. Patients care was supported with the right equipment.
- Medicines were stored and administered appropriately.
- Staff were aware of how to access guidance in the event of a major incident.

Incidents

- The emergency department had reported 12 serious incidents to the strategic executive information system between January 2015 and February 2016. These included five incidents where patient wait times exceeded 12 hours, one patient fall incident, an incident of delayed care and treatment, a communication issue with a patient's general practitioner (GP) that led to delayed treatment, two patient deaths, a medication incident and an incident involving inappropriate behaviour by a member of staff towards a patient.
- Trust records showed there were 1707 incidents reported in the department between January 2015 and December 2015. The most frequently reported incidents were 'patient watch (security) related' (354); 'patients absconded' (284) and 'extended waits for assessment greater than 12 hours' (156).
- We saw evidence that incidents were investigated and remedial actions were implemented to improve patient care. For example, staff made attempts to locate or contact patients that had absconded from the department and also notified the Police.
- Where incidents relating to extended wait times were reported these were reviewed to assess the impact on the individual patient's safety. An urgent care improvement plan was in place to address the issues around extended waiting times.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the clinical matron or lead consultant.
- Staff told us incidents were discussed during monthly quality and performance meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at. Learning from incidents was also shared across the department via noticeboards, newsletters and at daily 'safety huddle' meetings.

- The incident reporting system identified incidents that had led to serious or moderate harm to patients and prompted staff to apply duty of candour guidelines (being open and honest with patients when things go wrong).
- Incident reports showed that duty of candour guidelines had been applied where serious harm had occurred. This included a formal apology to the patient and their relatives along with an explanation of the remedial steps to be taken to address the issue. However no data was available to say if this action was timely
- Patient deaths were reviewed by individual consultants and were also reviewed at monthly quality and performance meetings.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections or C.difficile infections reported in the department during the past 12 months.
- The emergency department and observation ward were visibly clean, tidy and maintained to a good standard. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- Staff told us all patients admitted to the hospital were screened for MRSA. Patients identified with diarrhoea and vomiting symptoms were also screened for C.difficile. Patients with recent hospital admissions were also screened for Carbapenemase-producing Enterobacteriaceae (CPE).
- Records noted patients with known infections so they could easily be identified and treated appropriately. Staff told us patients identified with an infection could be barrier nursed in the single rooms (doored cubicles) within the department or transferred to the acute medical unit if isolation facilities were required.
- Staff carried out monthly monitoring of compliance in areas such as hand washing compliance and cleanliness of the environment and equipment.
- Hand hygiene audit results between December 2015 and February 2016 showed 100% compliance was achieved in most of the staff observations.
- The monthly environmental cleanliness audit results between April 2014 and November 2015 showed average compliance was 95% in the emergency department and 94% in the observation ward.
- The monthly equipment cleanliness audit results between April 2014 and November 2015 showed average compliance was 86% in the emergency department and 76% in the observation ward. This was below the trust target of 90%. The nursing and support staff were responsible for cleaning equipment. The department achieved a score of 100% during February 2016 and staff told us the recruitment of additional staff had contributed to improved compliance.

Environment and equipment

- The emergency department was well maintained, free from clutter and provided a secure environment for treating patients.
- The admission route was set up so that patients conveyed by ambulance and those at high risk were seen and triaged immediately. High risk patients were visible from the nursing stations for observation and timely intervention. There was clear segregation for adults and children that attended the department, including separate waiting, triage and assessment areas.
- There was a secure room that was used to assess patients with mental health needs. This was not a Section 136 room (a designated place of safety) under the Mental Health Act (1983). There was a designated Section 136 room on site that was managed by an external healthcare provider and patients could be transferred to this facility if needed.
- Adequate equipment was available in all areas including appropriate equipment for children. Staff told us the equipment needed was readily available and any faulty equipment could be replaced from the hospital's equipment store.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.

- Sterile procedure packs (such as for normal delivery and caesarean delivery) were available in the department. We saw these were stored securely and were routinely checked by staff to ensure they were kept within their expiry dates.
- Emergency bloods were stored in the hospital's pathology department and staff had 24-hour access to these if needed.
- Emergency resuscitation equipment was available in all the areas we inspected. We saw that daily and weekly equipment checklists were completed by staff.
- Patients conveyed by ambulance that were awaiting triage / assessment were accompanied by ambulance staff until they were admitted to a cubicle and had appropriate equipment such as oxygen made available to them.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines were ordered, stored and discarded safely and appropriately. A pharmacy technician visited the department three times per week and was responsible for maintaining minimum stock levels and checking medication expiry dates.
- Medicines for patients to take home were readily available and stored securely. Staff told us they could contact the pharmacy if any additional medicines were needed for a patient.
- Medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures. A fridge temperature log sheet for March 2016 showed there were six instances where temperatures of 8.3º to 8.7ºC had been recorded, which exceeded the maximum temperature range.
- Staff told us they contacted the pharmacy team and the trust's maintenance team where fridge temperatures exceeded the recommended temperatures. However, it was not clear if staff had contacted the pharmacy or maintenance teams in the instances where fridge temperatures exceeded the temperature ranges during March 2016.
- We looked at the medication charts for six patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- The initial patient triage process was recorded electronically. The electronic system also prompted staff to check for specific conditions, such as sepsis, pregnancy, airways issue or if the patient was a fitting child so that patients could be promptly placed on the appropriate care pathways.
- Staff used paper based patient clinical assessment records that included the patient's personal details, previous admissions and alerts for allergies and observations charts.
- We looked at the records for six patients. These were structured, legible, complete and up to date, with few errors or omissions. Patient records included risk assessments, such as for falls, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and medical assessments were carried out in a timely manner and documented correctly. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 97% of all staff in the department had completed adult safeguarding level 2 training and 99% had completed children's safeguarding level 2 training. This meant the trust target of 90% completion had been achieved.
- The records also showed that 81% of staff had completed adult safeguarding level 3 training and 97% of staff had completed children's level 3 safeguarding training. This meant the trust target of 80% compliance in this topic was achieved.
- Staff were aware of how to identify abuse and report safeguarding concerns. Policies outlined the processes for safeguarding vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding children and young people were identified.
- Staff could also obtain support and guidance the trust wide safeguarding team or from social workers that were based on site.

- Safeguarding incidents were reviewed by the clinical matron and also by the hospital's safeguarding committee, which held meetings every three months to review safeguarding incidents and look for trends and improvements.

Mandatory training

- Staff received mandatory training in key topics such as infection prevention, information governance, equality and human rights, dementia awareness, fire safety, medicines management, health safety and wellbeing, safeguarding children and vulnerable adults, moving and handling, major incidents and resuscitation training.
- The overall mandatory training completion rate for staff in the emergency department was 90%. This showed the majority of staff had completed their mandatory training and the trust's internal target of 90% compliance had been achieved.
- Staff within the emergency department also received adult and children's resuscitation training such as advanced life support and advanced paediatric life support training. Staff in the department also received advanced trauma life support training. Records showed completion rates for these were above the trust target (30%) and confirmed the majority of eligible staff had received resuscitation training.

Assessing and responding to patient risk

- An escalation policy was in place and bed management meetings took place three times per day to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues.
- Staff also carried out 'safety huddle' meetings during handovers where specific patient needs were discussed. Staff were aware of the actions to take if a patient's condition deteriorated and were supported with medical input.
- All patients with minor injuries who presented to the emergency department themselves (self-referral) were booked in via the receptionist and then triaged by a nurse who asked routine questions using a recognised triage system to determine the nature of the ailment.
- Patients who were conveyed by an ambulance were seen by a nurse via a separate entrance. We observed handovers of patients from the ambulance staff to the hospital staff. Patients were seen by the nurse in a dedicated triage bay so they could be assessed in a discreet and dignified manner.
- An appropriately qualified nurse triaged patients depending on the severity of their ailment and streamed patients to the appropriate route such as the minor or major injuries areas.
- Patients 16 years and younger had a dedicated waiting area before being triaged by a paediatric trained nurse.
- The average time to treatment was consistently worse than the 60 minute Department of Health (DH) standard between August 2015 and February 2016.
- The percentage of patients triaged within 15 minutes averaged 85.7% between February 2015 and September 2016. However, the average between October 2016 and January 2016 was 77.9%, indicating a worsening trend in performance.
- The national target is that handovers between ambulance and emergency department staff must take place within 15 minutes with no patients waiting more than 30 minutes.
- The department did not meet this target between April 2015 and January 2016. Records showed 851 handovers took between 30 and 60 minutes during this period.
- Handovers from ambulance arrival to the emergency department that take longer than 60 minutes are also referred to as 'black breaches'. There were 468 'black breaches' reported by the department between April 2015 and January 2016.
- Records showed 357 (76%) of these took place in the most recent three months between November 2015 and January 2016. Staff told us the 'black breaches' were mainly caused by an increase in the numbers of patients attending the department and also due to ambulances arriving together.
- The electronic admissions system alerted staff if any patients had attended the hospital or the emergency department previously so they could be referred to specific wards if needed.
- On admission, patients at high risk were placed on care pathways to ensure they received the right level of care.
- Staff followed guidelines and had 'care bundles' in place for the early recognition and management of patients with suspected sepsis including neutropenic sepsis.
- Staff used an early warning score system (a system that scores vital signs and is used as a tool for identifying

patients who are deteriorating clinically) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

Nursing staffing

- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.
- The clinical matron had overall responsibility for the nursing and support staff within the emergency department and the observation ward. There was a band 7 nurse coordinator on each shift. Nursing staff of differing grades were assigned to each of the patient areas within the department.
- The resuscitation area had five bays as well as separate adult and paediatric trauma bays. There was a band 6 nurse coordinator on each shift to provide clinical leadership and expertise, supported by two additional nurses during the early and late shifts and one nurse during the night shift.
- The major injuries area had three nurses on each shift, supported by two healthcare support workers during the early and late shifts and one support worker during the night.
- The minor injuries area had two nurses (a band 6 and band 5 nurse) on each shift, supported by a healthcare support worker during the early and late shifts. Patients with minor injuries were seen by emergency nurse practitioners (ENPs) between 8am and 10pm daily. There was at least one ENP in the department during these hours.
- There were separate ambulance and ambulatory triage nurses in place 24 hours per day.
- There were6.8 whole time equivalent (wte) paediatric nurses in post. The paediatric area had two paediatric trained nurses for 7.5 hours per day and at least one paediatric nurse in place at all other times.
- The observation ward had eight beds, split into four-bedded male and female bay areas. The ward was staffed with one nurse and one support worker on each shift. Staff told us the existing cover was sufficient for patients admitted specifically for observations, such as following a head injury.
- However, they told us the observation ward was routinely used to accommodate patients that were awaiting admission to other wards in the hospital if no beds were available. These patients often had greater care needs which meant there was additional pressure on the ward staff to provide appropriate care and treatment.
- There were vacancies for one band 6 nurse and five band 5 nurses. Recruitment for these was on-going with potential candidates at various stages of the recruitment process. There were six healthcare support worker vacancies and these had been fully recruited to with candidates either recently appointed or awaiting start dates.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. Where agency staff were used, the trust carried out checks to ensure that they had the right level of training in delivering emergency care.
- We found the department was busy during the inspection, with most cubicles occupied. As part of the escalation process, staff from the major injuries area would be allocated to the resuscitation area during busy periods in order to maintain a ratio of one nurse to every two patients. Subsequently, staff from the minor injuries area would be allocated to the major injuries area to maintain a ratio of one nurse to every four cubicles.
- The emergency department did not have sufficient numbers of nursing staff with an appropriate skill mix to ensure that patients received the right level of care. The existing establishment did not always have the flexibility to cope with the number of patients attending the department, especially during busy periods.
- An independent review of the nursing establishment was carried out during November 2015. This was based on National Institute for Health and Care Excellence (NICE) safer staffing standards. The staffing review recommended an increase to the current establishment by 15.80 whole time equivalent (wte) in order to fully meet safe staffing standards.
- The recommendations included the appointment of 5.99 wte band 6 nurses, 9.89 wte support workers and the appointment of a band 6 nurse coordinator to the observation ward to provide consistent leadership and embed pathways.
- The lead nurse for the urgent care directorate told us they had reviewed the findings from the staffing review and were in the process of developing a staffing structure that would take into account the findings from the review.

Urgent and emergency services

Medical staffing

- The emergency department had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients received the right level of care.
- All medical staff worked various shifts over a 24-hour period to cover rotas and to be on call during out-of-hours and weekends. There was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends.
- Medical staffing in the emergency department consisted of 11 consultants. Consultant cover during the week was available from 8am to 10pm on weekdays with either one or two consultants on site. At weekends one consultant was available in the department from 9am to 5pm**.** Outside of these hours, there was an on-call rota where consultants could be contacted at any time.
- There were eight specialty doctors, seven middle grade doctors and a team of junior doctors and GP trainees that worked a shift system. The establishment included six specialist trainee (ST4 or above) doctors, of which one was a training post.
- There were at least two middle grade doctors and four junior doctors present in the department from 8am to 2am with at least one middle grade doctor and two junior doctors between 2am and 8am.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they were subject to recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum and agency doctors had worked on extended contracts so they were familiar with the department's policies and procedures.
- There was a daily medical ward round on the observation ward. The lead consultant for the department told us there were no existing medical staff vacancies.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the emergency department, and this listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels.
- Guidance for staff in the event of a major incident was available in the department and staff were aware of how to access this information when needed. This included guidelines for dealing with chemical, biological, radiological, nuclear or explosive (CBRNE) hazards and the majority of staff (89%) had received CBRNE training.
- Security guards routinely patrolled the car park; corridors and public areas in the department. Staff could call security for immediate support or contact the Police if required.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- The department conducted a major incident simulation exercise as a desktop style review annually in accordance with the regulations of the Civil Contingencies Act 2004. The most recent simulation exercise was conducted during May 2015.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated this service as good for effective because:

- Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively.
- The emergency and urgent care services participated in national and local clinical audits.
- The services performed in line with other hospitals and performed within the England average for most safety and clinical performance measures.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team.

- Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

However:

- The department last participated in the CEM audit for severe sepsis and septic shock during 2011/12. We did not see any evidence to demonstrate how the department planned to improve compliance against the sepsis audit or how compliance was monitored since this audit. The department was scheduled to participate in the 2016/17 audit that was due to commence in August 2016.

Evidence-based care and treatment

- Care and treatment was evidence-based and staff provided care based on the National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (CEM) guidelines.
- Staff in the emergency department used a range of care pathways, in line with national guidance, such as for fractured neck of femur, trauma, sepsis, ambulatory emergency care guidelines and recognition of stroke in the emergency room pathways.
- The department was a major trauma receiving centre and collaborated with the Greater Manchester major trauma network. Care pathways were in place for child and adult trauma patients.
- The emergency department participated in local and national clinical audits, such as CEM audits. Findings from clinical audits were reviewed at monthly quality and performance meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- The staff we spoke with told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a selection of policies and procedures on the trust's intranet and the majority of these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A screening process identified any patients that required pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- There was a dedicated acute pain team within the hospital and staff knew how to contact them for advice and treatment if required.
- Patient records showed that patients that required pain relief were treated in a way that met their needs and reduced discomfort. The majority of patients we spoke with told us staff gave them pain relief medication when needed.

Nutrition and hydration

- The department had facilities to make drinks and snacks. We observed staff offering snacks and drinks to patients that had been in the department for an extended period of time.
- Patients that stayed overnight in the observation ward were offered a choice of meals. Staff on the ward carried out assessments of patients' nutritional requirements and there was regular dietician involvement with patients who were identified as being at risk.
- Staff on the observation ward were able to provide 'finger foods' for patients that experienced difficulties with eating. Volunteers attended the ward daily to assist patients during mealtimes.
- Staff also used the red tray system so patients who needed support with eating and drinking for example those living with dementia could be identified and supported during mealtimes

Patient outcomes

- The department participated in national CEM audits so they could assess their practice and performance against best practice standards.
- Audits included initial management of the fitting child, cognitive impairment in older people, mental health in the emergency department and consultant sign-off.
- The consultant sign-off 2013 audit showed the level of consultant contact with patients was similar to the national average. However, the number of patients seen by a senior doctor (specialist trainee grade 4 or above) was worse than the average.
- The cognitive impairment in older people 2014/15 audit showed the emergency department performed similar to the England average for most of the standards within the audit. However, the department performed below the national average for the proportion of patients that had an assessment of cognitive impairment. A dementia screening tool was put in place following the audit to improve compliance with this standard.

- The mental health in the emergency department 2014/15 audit showed the department performed similar to or better than the England average for most of the standards within the audit. The department performed below average for the proportion of patients that were assessed by a mental health practitioner. Staff received additional training and raised awareness of the process for referring patients to the rapid assessment interface and discharge (RAID) team for patients identified with mental health needs.
- The initial management of the fitting child 2014/15 audit showed the department performed similar to the England average for the management of children actively fitting on arrival and the recording of presumed aetiology (causes). The department performed worse than the average for the recording of eye witness history and the proportion of discharged patients whose parents or carers were provided with written safety information. Actions taken to improve compliance included additional training and raised awareness of the need to record eye witness history and the development of patient information leaflets for discharged patients.
- The department last participated in the CEM audit for severe sepsis and septic shock during 2011/12. The audit showed performance was better than the national average for six out of the 11 indicators covered by the audit.
- The department performed worse than the national average for five indicators including whether high flow oxygen was initiated, first intravenous crystalloid fluid bolus was given and that urine output measurements were instituted in the department.
- We did not see any evidence to demonstrate how the department planned to improve compliance against the sepsis audit or how compliance was monitored since the 2011/12 audit. The department did not participate in the 2013/14 sepsis audit but was scheduled to participate in the 2016/17 audit that was due to commence in August 2016.
- The rate of unplanned re-attendance to the emergency department within seven days of previous attendance was above the 5% target set by the Department of Health but fluctuated slightly above and below the England average (7.5% – 8%) between April 2015 and January 2016.

Competent staff

- The department had a practice educator that oversaw training processes and carried out competency assessments. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Student nurses were assigned a mentor and worked supernumerary during their first four weeks.
- Staff told us they routinely received supervision and annual appraisals. Records showed all the nursing and medical staff across the department had completed their appraisals.
- The lead consultant told us all eligible medical staff in the emergency department that had reached their revalidation date had been reviewed and recommended for revalidation with the General Medical Council.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.
- The nursing staff told us they felt training in trauma could be improved. A nurse was currently being trained to be an instructor in the advanced trauma nursing course (ATNC) with a view to roll out this training to nursing staff across the department.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the emergency department. Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks and concerns. The nursing staff had good relationships with the consultants, doctors and emergency nurse practitioners.
- There were routine multidisciplinary meetings involving the nursing staff, therapists, medical staff and social workers to assess patient's needs and identify any support needed from other providers on discharge, such as home care support.
- A social worker was based on site to provide support for the emergency department and observation ward during weekdays and on weekends. Their main role was to facilitate the discharge of patients that required a complex care package.
- The rapid assessment interface and discharge (RAID) team provided 24 hour support to patients with psychiatric issues and supported the staff in the emergency department. The team had specific pathways, management plans and confidential systems in place to support patients with mental health needs.

Urgent and emergency services

- The RAID alcohol liaison support was available 9am to 5pm during weekdays and patients could be referred to the service outside of these hours.
- Patients with complex mental health needs could be referred to psychiatric services or child and adolescent mental health services (CAMHS) that were available on site and provided by an external healthcare provider.
- Physiotherapy and occupational therapy support was available in the department between 8am and 8pm seven days per week and available on-call during out-of-hours.
- There was evidence of good partnership working with the regional ambulance service, with regular meetings between staff from the department and the liaison officer from the ambulance service to reduce ambulance delays.
- Staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers, mental health liaison, and alcohol liaison as well as diagnostic support such as for x-rays and scans. However, they told us they sometimes experienced delays in receiving CT scan results.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the emergency department by junior and middle grade doctors as well as on-site and on-call consultant cover.
- Diagnostic support (e.g. x-rays), physiotherapy, pharmacy, occupational therapy, alcohol liaison, mental health liaison and social worker support was available during weekdays and during the day at weekends. Support was also available on-call outside of normal working hours and at weekends. The dispensary was open for a limited number of hours on Saturdays.
- The emergency department staff told us they received good support from other disciplines outside normal working hours and at weekends.

Access to information

- The department used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from arrival to the department through to discharge or admission to the wards. This meant that staff could access all the information needed about the patient at any time.
- The department used an electronic system to track when patients were admitted to the department. Staff told us the information about patients they cared for was easily accessible.
- Notice boards were used to highlight where patients were located within the department and to identify high risk patients such as patients living with dementia or those identified as being at risk of falls.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the skills and knowledge to ask patients for consent and were able to explain how they sought verbal, implied and informed consent. Written consent was sought before providing specific treatments such as anaesthetics.
- Staff received training in and understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLs).
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient.

Are urgent and emergency services caring?

Good

We rated this service as good for caring because;

- Patients spoke positively about their care and treatment. They were treated with dignity and compassion.
- Data for patient satisfaction surveys showed the department scored worse that the England average for the number of patients that would recommend the emergency department to friends and family.
- Staff kept patients and their relatives involved in their care.
- Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

Urgent and emergency services

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. We saw that patients' cubicle curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- The ambulance triage room had a curtain that segregated the room from the main corridor. We saw patients awaiting ambulance triage queued up in the corridor during busy periods which meant their privacy and dignity could not be fully maintained.
- We spoke with seven patients. All the patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "very good care, no problems, great service" and "all the staff are polite".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between January 2015 and January 2016 showed the emergency department's average score was 86% and worse than the England average (88%) during this period, indicating that a significant proportion of patients would not recommend the hospital to friends and family.
- The CQC's accident and emergency survey 2014 showed the trust was about the same compared with other trusts for all sections, based on 241 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patients told us the medical staff had clearly explained their care and treatment to them. Relatives and patients' representatives were consulted in discussions about the planning process for discharge from the observation ward.

Emotional support

- We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.
- There were two relatives' rooms in the department that could be used by the relatives of patients that had been involved in traumatic incidents.
- Information leaflets were available to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Staff could access management support or counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as a fatal road traffic accident, or if they had been subject to a negative experience.
- Nursing and medical staff were included in debriefing sessions after traumatic events.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated this service as requires improvement for responsive because:

- Patients attending the department experienced extended delays before they received treatment. This is in breach of regulation 12 2(a) (b) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The emergency department consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.38% during this period.
- There were nine instances where patients had trolley waits of more than 12 hours between November 2015 and February 2016.This included five breaches reported during February 2016.
- There were 38 complaints relating to the emergency department between January 2015 and December 2015. However, only four of these were resolved within the trusts specified timeline of 60 days.

However:

- The urgent care improvement plan was in place to improve performance against waiting time targets. This

included actions to formalise escalation processes, review staffing arrangements and implement rapid assessment and treatment (RAT) processes. These actions were planned for completion by August 2016.
- There were systems in place to meet the needs of vulnerable patients, such as patients living with dementia or a learning disability.

Service planning and delivery to meet the needs of local people

- The emergency department provided care and treatment for patients across Oldham and the surrounding areas. Records showed that 97,716 patients attended the department between November 2014 and November 2015 with an average monthly attendance of 1,879 during this period.
- The emergency department was a receiving centre for major trauma patients. Staff followed a trauma pathway which provided guidance for staff on the process for stabilising patients prior to transferring them to the regional major trauma centres.
- There was an escalation policy that provided guidance for staff when dealing with periods where there was significant demand for services. Bed management meetings took place three times per day to monitor capacity and patient flow within the department.
- 75% of patients attending the emergency department were adults with the remaining 25% were children up to16 years of age. There were suitable and segregated waiting areas for both adults and children with sufficient seating arrangements.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Staff used a 'forget me not' document for patients learning disabilities or living with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. Staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could contact the social workers or mental health liaison team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff could access appropriate equipment, such as specialist commodes, trolleys or chairs to support the moving and handling of bariatric patients (patients with obesity).

Access and flow

- The average length of stay on the observation ward was 0.85 days between August 2015 and January 2016, which meant most patients only stayed on the ward for a short period of time.
- The Department of Health (DH) target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The emergency department consistently failed to meet this target between April 2015 and February 2016.
- The percentage of patients per month that were treated within four hours of arrival ranged between 72.96% and 96.18%, with an overall average of 84.38% of patients seen within four hours during this period.
- Records showed the department achieved the 95% target in only six weeks during this period. This included five weeks where waiting time standards were achieved during June and July 2015 as the department participated in a 'perfect week' exercise during June 2015 and this had a positive impact on patient flow and performance against waiting time standards.
- The average total time spent in the emergency department by admitted and non-admitted patients was higher than the England average between August 2015 and February 2016.
- The percentage of emergency admissions waiting between four and 12 hours to be admitted was similar to the England average between August 2014 and June 2015, rising above the average during July 2015 to August 2015.
- The department failed to meet the DH guidelines relating to trolley waits as nine incidents were reported where patients had trolley waits of more than 12 hours between November 2015 and February 2016. This included five breaches reported during February 2016 indicating a worsening trend. There were no reported 12-hour trolley breaches in the department between February 2015 and October 2015.

Urgent and emergency services

- NHS England guidelines state 'the time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient or the time when treatment that must be carried out in A&E before admission is complete – whichever is the later.'
- The emergency department had historically recorded the decision to admit (DTA) time as decision at the point of referral to speciality. Since February 2016, the department was trialling a process where the DTA time was recorded at the point when the decision to admit was made by the emergency department clinician. The change in reporting DTA processes could account for the increased number of 12-hour trolley wait breaches reported by the department.
- The proportion of patients leaving the department without being seen (3.82%) was within the DH target of 5% but higher (worse) than the England average between February 2015 and January 2016.
- We observed patients in the department that self-presented or arrived via ambulance. The department was busy with a regular influx of ambulatory patients and ambulance patients awaiting treatment.
- During the unannounced inspection there had been 187 attendances between 12am and 5pm. Fairfield General Hospital had issued an ambulance divert protocol for a two hour period, which meant there was an increased number of ambulance patients in the department.
- Staff in the department were busy and attempted to manage patient flow but we saw that some patients did not receive treatment in a timely manner. There was insufficient capacity and cubicle space to treat the number of patients arriving in the department. For example, the minor injuries area was often used to accommodate patients when the major injuries area became full.
- The patients we spoke with during the inspection told us they had experienced long waiting times ranging from 1.5 hours to four hours.
- The ambulance crews accompanied the patient until a cubicle was found. The ambulance staff we spoke with told us they sometimes waited up to 5 hours before patients were transferred to a cubicle.
- During the unannounced inspection there were two four-hour wait breaches and a 12-hour trolley wait breach in the department. Staff told us the 12-hour trolley wait patient had received treatment and was awaiting discharge which meant the delay in treatment did not impact the safety of the patient.
- The department reported 12-hour breaches as serious incidents and carried out root cause investigations where ambulance handover delays exceeded two hours.
- The main reason for delayed treatment and waiting time breaches was due to capacity constraints in other parts of the hospital (referred to as 'exit blocking'). This means patients could not be admitted and transferred to the wards in a timely manner.
- The urgent care improvement plan was in place to improve performance against waiting time targets. This included actions to formalise escalation processes, review staffing arrangements and implement rapid assessment and treatment (RAT) processes. Key actions listed in the improvement plan were planned for completion by August 2016.

Learning from complaints and concerns

- The emergency department had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the patient advice and liaison service. The patients we spoke with were aware of the process for raising their concerns with the trust.
- The trust's complaint policy stated that complaints would be acknowledged within three working days and resolved within 25 working days for routine complaints or within 60 days for complex complaints that required investigation or root cause analysis.
- There were 38 complaints relating to the emergency department between January 2015 and December 2015.
- Records showed 26 of these complaints had been resolved but only 10 of these were resolved within 60 days. The remaining 12 complaints were still being investigated. The most frequent reasons for complaints were due to a failure to treat or diagnose patients appropriately or due to delayed treatment or diagnosis.
- Information about complaints was discussed during monthly quality and performance meetings to raise staff awareness and to aid future learning.

Are urgent and emergency services well-led?

Urgent and emergency services

Requires improvement

We rated this service as requires improvement for well-led because:

- The urgent care directorate was formed recently and the clinical director and lead nurse for urgent care services across the trust had only been in post since December 2015 and January 2016 respectively. The management team understood the key risks and challenges to the service but had only been in their roles for a short period of time. This meant formal plans to address these risks were not yet in place.
- The emergency department did not have a documented strategy specifically for the service. The clinical director was in the process of developing a new strategy.
- The clinical governance system allowed key risks to be escalated and these risks were monitored through monthly quality and performance meetings. However, the length of time taken to respond to these risks meant the department did not have a proactive risk management process.

However:

- The service delivery was based on the trust values and core objectives and staff had a clear understanding of what these involved.
- There was effective local leadership and staff spoke positively about the support received from the lead consultant and clinical matron.
- Most staff were positive about the culture within the department and the level of engagement from their managers. Staff sickness and turnover rates within the department were better than the overall trust and England averages.

Vision and strategy for this service

- The trust vision was to become 'a leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.' This was underpinned by a set of values that were based on being 'quality driven', 'responsible' and 'compassionate'.
- As part of the trust's overall strategy there were six strategic goals and 10 core priorities for 2015/16 that covered a range of areas including patient safety, improving quality and performance, clinical and financial sustainability and improving staff morale and leadership.
- The trust vision and values had been cascaded to staff across the emergency department and staff had a clear understanding of what these involved.
- The emergency department did not have a documented strategy specifically for the service. However, the service delivery was based on the trust values and key objectives and performance targets were based on the trust values and core objectives.
- The clinical director was in the process of developing a new strategy for the urgent and emergency services across the trust

Governance, risk management and quality measurement

- There were monthly quality and performance meetings that took place at departmental, directorate and divisional level. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- There were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- The emergency department held risk assessments for low level local departmental risks. The clinical governance system allowed for key risks to be escalated to the urgent care directorate and the medicine divisional risk registers.
- The directorate and divisional risk registers listed the key risks relating to the service and showed that key risks had been identified and escalated appropriately. However, we found that remedial actions to address these risks were not always put in place in a proactive and timely manner.
- For example, two of the risks identified on the divisional risk register related to a 'failure to achieve the four-hour wait standards caused by increased demand and reduced capacity' and 'failure to achieve safe staffing levels, caused by the inability to recruit or retain medical and nursing staff'. Both these risks had been on the risk register since October 2013 without formal resolution. A

staffing review and urgent care improvement plan was in place to address these risks. However, the length of time taken to respond to these risks showed that a proactive approach had not been taken.
- Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff via staff meetings, emails and via the trust intranet. The divisional director for urgent care told us they planned to introduce performance dashboards in the future so that access to performance information could be more accessible.

Leadership of service

- The emergency department at the hospital had clearly defined and visible local leadership. There was a lead consultant and clinical matron in place to manage the day-to-day running of the department. The nursing and medical staff told us they understood the reporting structures clearly and that they received good management support.
- The emergency department was incorporated into the urgent care directorate, which formed part of the medicine division. The urgent care directorate was formed during 2015 to provide a combined leadership structure across all the trust's emergency services.
- The urgent care directorate leadership team was recently formed. The overall lead for emergency services across the trust was the clinical director for urgent care, who had been in post since December 2015. The clinical director was supported by the interim divisional director for urgent care and the lead nurse for urgent care, who had been in post since January 2016.
- The clinical director told us the emergency services across the trust had historically operated as stand-alone departments within their respective hospitals and part of the future strategy was to promote harmonised practices and cross-working across the trust's four emergency departments. The clinical director and lead nurse visited the emergency department at the hospital on a weekly basis to support the lead consultant and clinical matron.

Culture within the service

- All the staff we spoke with were highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- Junior doctors and nurses also told us they received a good level of support from their peers and line managers.
- The medical and nursing staff worked well as a team but staff morale had been low in the past because of staffing issues and the increased workload from the high volume of patients that attended the department. Staff told us morale had improved over the last few months with the recruitment of additional staff.
- The staff sickness rate between May and December 2015 was 0.95% for medical staff and 4.1% for nursing staff. This was better than the trust target of 5.87% and similar to the England average during this period.
- The staff turnover rate between May and December 2015 was 0% for medical staff and 1.36% for nursing staff. This was better than the trust target of 8%.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on how the public could provide feedback was displayed in the department and feedback mechanisms for the public to engage with the trust were also available on the internet site.

Staff engagement

- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings.
- Managers also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

Innovation, improvement and sustainability

- The clinical director and lead nurse told us the key risks to the service were around staffing levels and the flow of patients out of the emergency department. They were confident the outcomes of the staffing review and urgent care improvement plan would address these risks.

Urgent and emergency services

- The emergency department and directorate leads were aware that the “devolution of Manchester” proposals could have an impact on services in the future but they felt confident about the sustainability of the services at the hospital.

Medical care (including older people's care)

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

Information about the service

Medical care services at the Royal Oldham Hospital provides care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology. The hospital also offers specialist services such as clinical haematology. The hospital serves a population size of approximately 221,000 and employs 386 whole time equivalent nursing staff in medical services and has 210 beds. Medical services trust-wide had 85,026 admissions between February 2015 and January 2016.

We visited Royal Oldham Hospital as part of our announced inspection on 24 February 2016

As part of the inspection, we visited the acute medical unit, ambulatory care, discharge unit, the endoscopy unit, ward F10 (general medicine) and ward F7 (respiratory).

We reviewed the environment and staffing levels and looked at 24 care records. We spoke with seven family members, five patients and 43 staff of different grades, including nurses, doctors, ward managers, occupational therapists, a housekeeper, a volunteer, estates staff, student nurses and the senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We observed how care and treatment was provided.

Summary of findings

We rated medical care services as requires improvement overall because:

- There were standards for record keeping that required improvement but records did include a treatment plan for each patient. Clinical staff had access to information they required, however, we found records were left unsecured on the acute medical unit and there was a risk personal information was available to members of the public.
- Resuscitation equipment was not always being checked and equipment could be accessed even though tamper seals were in place. There were a number of pieces of electrical equipment which had out of date safety certificates and oxygen was not being stored in line with guidance.
- There had been incidents of missing medication on the acute medical unit and training levels in medicines management was low but there were safe systems for the handling and disposal of medications.
- Staffing levels were largely adequate to meet the needs of patients but there were occasions on wards when there had been a reliance on agency or bank nurses as well as locum doctors.
- Staff were not always following trust policies and procedures in relation to assessing patients for capacity to provide informed consent and the

completion of capacity assessments. Nursing staff were unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint.

- There was insufficient bed capacity on occasions to meet the needs of people within the hospital but there where systems in place to ensure they were reviewed by the medical team. Some patients had to stay in hospital longer than was needed due to care packages not being in place when they were ready for discharge. There were also a number of patients who did not stay in the same ward for the entirety of their time in hospital.
- Patients were not always supported with hydration and nutrition and there was limited staff interaction with patients.
- There were governance structures in place which included a risk register. However, some risks on the register had been there since 2011 and there were new ones identified which had a future date. It was unclear if learning was shared wider across other service areas and there were times when complaints took a long time to resolve

However:

- There were systems in place to protect people from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse.
- Incidents were reported by staff through effective systems and lessons were learnt and investigation findings and improvements made were fed back to staff at a local level.
- The hospital was visibly clean and staff followed good hygiene practices.
- Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a leaf symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs.
- People were supported to raise a concern or a complaint and lessons were learnt and improvements made. Medical services captured views of people who used the services with changes made following feedback.
- All staff were motivated to work at the hospital.
- All staff knew the trust vision and behavioural framework and said they felt supported and that morale was good.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical services as 'Requires Improvement' for safe because:

- There was good monitoring of infection control practices although we did not see any evidence of actions to improve standards.
- Cleaning chemicals were left out in an unlocked room on a number of wards and there were trolleys containing sharp instruments which were not locked away and had been left unattended.
- Oxygen cylinders were not always stored in line with health and safety best practice guidelines.
- Resuscitation equipment had tamper seals in place but the equipment drawers could still be opened. Staff were not aware of this.
- Equipment checks were not always completed on the acute medical unit which meant there was a risk that equipment might not always be available when needed.
- There were a number of items of electrical equipment on the endoscopy unit and acute medical unit that did not have up to date electrical safety certificates.
- There were safe systems for the handling and disposal of medicines. However, on the acute medical unit there had been incidents of missing controlled medication and fridge temperature checks had not always been completed.
- Just over half of the staff required to undertake medicines management training had completed it at the time of the inspection.
- Records we looked at were not always documented accurately. Records trolleys were left unlocked on the acute medical unit.
- Nurse staffing levels were overall sufficient to meet the needs of patients but there had been a reliance on temporary staff on the some of the wards as well as the use of locum doctors

However,

- Staff attended mandatory training courses and compliance rates were above the trust target.
- Where there were staff vacancies these had been noted on the risk register and actions identified to mitigate this risk.
- Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations.
- Medical wards at the hospital were generally visibly clean and staff followed good hygiene practice, although we saw limited use of the 'I am clean' stickers on equipment on the wards.

Incidents

- Staff were familiar with and encouraged to use the trust's policy and procedures for reporting incidents. Incidents were reported through the trust's electronic reporting system and we spoke with a range of staff across the service who were all aware of how to report incidents.
- Staff were able to provide us with examples of when they had reported incidents, and understood what constituted an incident. For example, when a patient had fallen or when medication had been missed as a patient was off the ward for clinical investigation.
- There had been no never events reported in medical services between December 2014 and November 2015(Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented).
- Between December 2014 and November 2015 there were 1,222 incidents reported in medical services at the hospital. Of these, 1111 resulted in low or no harm to patients.
- Between December 2014 and November 2015, 26 serious incidents were reported throughout medical services at the trust. We could not disaggregate the number for this hospital. Information showed slips, trips and falls was a commonly occurring incident followed by delay in treatment and sub-optimal care of deteriorating patients.
- A root cause analysis tool was used to investigate serious incidents, and we saw where required an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning which were shared with clinical teams and the wider trust. .
- Senior staff told us general feedback on patient safety information was discussed at ward managers meetings, ward staff meetings or in staff huddles. On the wards we visited senior staff met with ward staff to look at lessons learnt from incidents.

- Ward rounds assisted learning from incidents and staff were able to give us an example when this had happened. Ward rounds are formal meetings for doctors to discuss clinical issues and learning.
- Staff told us they received feedback from incidents from services across the trust via an electronic lessons learnt bulletin for the service on a monthly basis. Staff were able to describe an example of a change following an incident. For example, after an investigation into an incident, intentional observation rounding logs were introduced on the ward to ensure all patients had been seen by the nurse every 2 to 4 hours.
- Information about incidents was discussed for medical care as part of the Divisional and Directorate Quality and Performance meetings. However, on reviewing the minutes of the meeting for September, October and November 2015, it did not appear that learning was discussed although the number and outstanding action plans were discussed.
- The audit programme for April 2016 to March 2017 showed that audits were planned to check that changes to practice following investigations were embedded.
- Mortality and morbidity meetings were held on a monthly basis and actions and learning were identified but it wasn't always clear who was responsible for their implementation or the timeframe that it would be expected in.
- Staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when this had been implemented. The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- Safety thermometer information was for medical services across the trust showed that between November 2014 and December 2015, there had been a total of 34 CAUTI's, 59 pressure ulcers and 89 falls that resulted in harm.
- There were 362 recorded incidents of falls between December 2014 and November 2015 at the hospital, with 357 resulting in low or no harm to patients.
- The service was monitoring incidents of pressure ulcers and falls through their performance dashboard each month and these were reported to the trust quality and performance committee and the board.
- The issue of falls was recorded on the medical division risk register with actions and timescales to lower the risk, for example ensuring that all staff followed the trust's falls policy and completed the risk assessments.
- Safety thermometer information was prominently displayed on all of the medical wards and units we visited for patients and the public to see.
- Senior staff were aware of changes in practice that had taken place as a result of a recent safety thermometer audit. This included additional training for staff to be able to recognise pressure ulcers and record the data accurately.
- On ward F7, the service was trialling a new mat on top of mattresses to help identify when staff should reposition a patient correctly to help avoid pressure ulcers. They were also trialling falls sensors on chairs for patients who were at risk of falling on wards F7 and F10.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow guidance and using personal protective equipment (PPE) where appropriate.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas and appropriate signage, regarding hand washing for staff and visitors, was on display.
- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room.

- However, the trust did not use different coloured PPE equipment, for example yellow aprons instead of white aprons, to indicate they were providing care for patients with an infection.
- Between January 2015 and November 2015 medical services trust-wide reported 28 cases of clostridium difficile infections and five cases of methicillin-resistant staphylococcus aureus (MRSA). However, this could not be disaggregated specifically for medical services at the Royal Oldham Hospital
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use but this wasn't consistent in all areas. For example, the majority of commodes on ward F10 did not have stickers; it was therefore difficult to be certain if they had been cleaned.
- The wards we visited were visibly clean and free from odour; we observed the cleaning of the environment whilst we were on the wards.
- Monthly infection control audits were undertaken across all wards which looked at standards such as cleaning schedules of commodes and implementation of trust policy. The results showed that the majority of medical wards were above the trust target of 88% in October 2015. However, ward F10 scored 67% and the acute medical unit 75%. No actions for improvement on F10 and acute medical unit were recorded on the information provided by the trust.
- Monthly hand hygiene audits were undertaken by staff being observed. The results were mostly around 100% across medical and care of the elderly wards. However, we looked at the results of four audits which showed wards F7, F8, F10 and the acute medical units were not always achieving 100%. For example in September 2015 ward F7 and F8 scores were 67% and in October 2015 ward F8 score was 77%. No actions were recorded on the information provided by the trust which showed how they were going to improve standards.
- Monthly cleaning audits were also undertaken with a trust target of 90% for medical wards. The results were variable across the ward areas and in October 2015 ambulatory care scored 75% and ward F10 scored 67%. No actions were recorded on the information provided by the trust to show how they were going to improve standards.
- We observed the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use.
- Cleaning schedules were in place and completed as required to indicate that cleaning had taken place.
- Wards were using the national colour coding scheme for hospital cleaning materials and equipment so that items were not used in multiple areas, therefore reducing the risk of cross infection.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside the majority of wards to identify themselves on arrival before they were able to access the ward and staff had access codes.
- Areas we visited were bright and well organised. Due to the size of the acute medical unit a tannoy system was in place to alert staff to meetings or any issues that may need attention. This was noisy at times for patients who may be resting during the day.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the majority of wards we visited. However, on the acute medical unit the equipment had not been checked on four occasions since 25 January 2016. Staff said they had not reported this as an incident.
- None of the resuscitation trolleys were locked and although there was a tamper proof seal in place, we were able to open the trolleys without the seal breaking. This appeared to be a design fault and when we raised this with staff they were not aware of the problem. This meant there was a risk that emergency equipment could be tampered with or removed without staff being aware of it.
- There were systems in place to maintain and service equipment as required. Records indicated defibrillator equipment had been checked and hoists had been serviced regularly.
- Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date on most of the wards. However, there were a number of pieces of equipment on the

endoscopy unit that did not have up to date certificates, such as a suction machine and defibrillator. Suction machines attached to the resuscitation equipment on the acute medical unit also had out of date certificates.

- Cleaning chemicals were left in an unlocked area on the acute medical unit, although the room and cupboard were lockable. They were also not locked away on the discharge unit. These should have been stored securely as the chemicals were potentially hazardous and presented a risk to people's health.
- On the acute medical unit portable oxygen cylinders were not stored in a locked room or secured in a cage or against a wall. Portable oxygen cylinders on the resuscitation trollies were also not secured. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well ventilated storage area or compound when not in use.
- On ward F10, there were needles and scissors stored in a room that was not locked and accessible to patients and the public. Similarly, on the acute medical unit, needles and sharp instruments were in an unlocked trolley which was accessible to patients and the public
- Trust patient led assessments of the environment (PLACE) in 2015 showed a standard of 100% in cleanliness and 98 % for facilities. Both these scores were above the England average.

Medicines

- Medicines were prescribed electronically throughout the medical specialities and the care of the elderly wards.
- Between December 2014 and November 2015 there had been 56 medication errors reported in medical services at the hospital. Of these, 55 resulted in low or no harm. All medication errors and reds were discussed at the trust Medication Safety Committee and divisional Drugs and Therapeutic Committees.
- Specific staff had been identified to undertake medicines management training and only 67% of staff in medical services at the hospital had completed this training.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were mostly completed on the wards we visited. However, on the acute medical unit they had not been completed in January 2016 on three occasions and eight occasions in February 2016. Staff were able to tell us the system identified to follow up if there were gaps in these records.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the trust. We reviewed a sample of stock balance records for controlled drugs and found they were mostly correct. However, on the acute medical unit we found there had been incidents where the quantity of controlled drugs did not balance. The discrepancy had been highlighted to the senior nurse who had completed an incident form but we were not fully assured that this had been fully investigated. As a result, it was unclear what had happened and no lessons learnt had been identified to ensure it did not happen again.
- Emergency medicines were available for use and records indicated that these were regularly checked and were in containers with tamper-seals in place on the majority of the wards. However, on the acute medical unit the tamper-seal had been broken. This meant there was a risk that emergency medication could have been used or tampered with and may not have been available in an emergency as a result.
- Suitable cupboards and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. We sample checked medicines on the wards and found them to be in date, indicating there was good stock management systems in place.
- We observed a medication round on ward F10. We saw that the nurse was constantly being interrupted whilst administering medication. This meant there was a risk that the member of staff may have made a medication error or given prescribed medication to the wrong person.
- Patients had been provided with a lockable drawer in which to store their medication, enabling them to continue to take their medication at the times they were used to taking it at home. This meant that patients were given a choice and steps were taken to maintain their independence.
- A pharmacist visited medical wards each week day. Pharmacy staff said they checked that the medicines patients were taking when they were admitted to the wards were correct and records were up to date.

- There were monthly medicines management audits as part of the nursing metrics. We looked at the findings between October 2015 and January 2016 and saw wards across the trust were scoring above 90% compliance with standards. The information provided by the trust did not identify any actions for wards to implement to improve any of the standards.
- The service undertook regular 'use of antibiotics' audits. The last audit showed poor recording of the review and stop dates of antibiotics. Recommendations were identified to improve standards which included re-auditing to monitor improvements.

Records

- We observed for each patient there were up to three sets of records which were a mixture of paper based records and electronic records. This meant there may be a risk that important information may be difficult to find in an emergency.
- Medical services undertook an annual medical records audit. In 2015, out of the 13 standards assessed in the audit, none achieved above 95% compliance. The results showed that 85% of entries were dated. However, only 10% of staff entries included the name and speciality of the clinical lead in charge of care. There were concerns that only 53% of pages in patient records had the patient name recorded, which was an increase from 34% the previous year but still meant there was a risk that important patient information may be mislaid or filed in the incorrect record.
- Also of concern was that only 3% of entries made by non-registered practitioners, for example student nurses, had been counter signed by the supervising health care professional. This meant there was a risk that incomplete or incorrect information may have gone un-noticed if not checked by the supervisor.
- Medical services had put in place an action plan to improve standards. For example ensuring that ward clerks inserted blank history sheets with patient identification visible on every side in patient records and ensuring all junior doctors attend the mandatory record keeping training. Data provided by the trust showed that at the time of the inspection, 93% of doctors at the hospital had completed their information governance training. This training included how to meet standards required to handle patient information. We noted that there was no action on the action plan to improve the standard of counter signing entries made by non-registered practitioners.
- We reviewed 24 care records and saw that recent entries were legible, signed but not always dated. They were also not easy to follow but medical staff had documented detailed information for patient's care and treatment.
- Documentation kept to record people's vital signs, fluid balance charts and food intake were variable. For example, there were issues with incomplete initial assessments by medical staff and in three of the records for people who required intravenous fluid on the acute medical unit, none of the charts were fully completed and one did not have a fluid balance chart in their records.
- We looked at seven records to see if the patients had been seen by a consultant within 12 hours of admission but only four patients were recorded as being seen in the timeframe.
- On ward G1 we saw there was loose paper containing patient information in a patient record we reviewed. This meant there was a risk important information may get mislaid. On this ward the bedside patient notes, which contained risk assessments and observation sheets, had a generic contents sheet which made it difficult to see what assessments should have been completed for each patient. We raised this with the ward manager who said they would discuss this at the next ward meeting.
- Patient records included a range of risk assessments and care plans were completed on admission and updated throughout a patient's stay.
- Wards had lockable patient note trolleys. On most wards, patients' notes were kept away from patient and public areas. However, on the acute medical unit we observed these trolleys containing patient notes were left opened and unattended in the corridors. This increased the potential for patient confidentiality to be breached.
- The trust had begun to implement a new electronic record system to record all aspects of patient care. Staff told us that there had been problems with the recording of care plans on the system and was no longer being used on the acute medical unit until these issues were resolved. However, the system was being piloted on F10 at the time of the inspection.

- The patient information boards visible in ward corridors respected patient confidentiality by patient names being covered up. Patient information boards were used to provide at a glance an overview of the key risks, medication and discharge plans for each patient.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team that provided guidance during the day, Monday to Friday. Staff had access to advice out of hours and at weekends from the hospital on-call manager.
- Between April 2014 and March 2015 there had been 324 adult safeguarding referrals, from across all services at the hospital made to the trust safeguarding team.
- Training statistics provided by the trust showed in medical services at the hospital all staff had completed safeguarding adults level 2 training and all of staff had completed safeguarding children level 2 training.
- Basic safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- Staff we spoke to had a clear understanding of the trust safeguarding policy. We observed staff handling of a safeguarding issue after a patient made an allegation about staff whilst we were on the ward. Staff handled this sensitively and appropriately but did need an initial prompt from the inspection team to put in the safeguarding referral.

Mandatory training

- Staff received mandatory and statutory training on a rolling annual basis in areas such as infection control, manual handling and fire.
- At the time of our inspection, 98% of staff in medical services at the hospital had completed their required training which was above the trust target of 90%.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition deteriorated. The MEWS system used clinical observations within set parameters to determine how unwell a patient was. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above).
- A MEWS score was required as part of the patient's initial assessment, and at intervals for routine monitoring for example every two hours.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. Repeated checks of the early warning scores were documented accurately.
- An audit of the MEWS system was completed in September 2015. The overall results were positive but additional actions were in place to improve care. This included ensuring ward rounds for patients over 85 year old , with one or more additional disorders or diseases, were undertaken regularly rather than on an ad-hoc basis.
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).
- Intentional observation rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. On ward G1 we saw that for two patients these had not been completed accurately and it was unclear if they had been undertaken.
- The service undertook nursing metrics every month where the allocated matron visited the ward area to look at medication, documentation, observations, nutrition and infection control
- The results for July 2015 to September 2015 showed overall the results were good but there were still areas of concerns. For example nutrition and continence management. Actions plans were in place to improve standards.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust

on a six monthly basis. The last audit was in November 2015. This review showed the wards were safely staffed but noted the high level of sickness and vacancies in the service which were being covered by temporary staff.

- Matrons met each day to discuss nurse staffing levels across medical services to ensure that there was good allocation of staff and skills were appropriately deployed and shared across all wards.
- At the end of November 2015 the vacancy rate for nursing staff in medical services trust-wide was 7% and this was recorded on the risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme. Managers knew where there were shortfalls and where there was surplus on other wards so that staff that could be called on if needed and vacancies were being covered by using agency or bank staff.
- We reviewed the use of agency and bank nurses between April 2014 and March 2015 and found there were a number of wards which used temporary staff quite regularly. For example, on ward G1 100% of shifts were filled with temporary staff in January and February 2015 and ward F7 averaged around 22% of shifts filled throughout the year.
- Clinical support workers raised concerns about staffing levels across medical services at the hospital and told us when patients required 1:1 enhanced care this left ward areas short of support staff as these shifts were not backfilled. We reviewed the staffing figures for August 2015 to November 2015 and found that there were shifts that had above 100% of shifts filled as planned which indicated additional clinical support workers on the wards.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- The trust used the national benchmark of 80% of nursing shifts would be filled as planned during the day and night. We reviewed staffing figures for August 2015 to November 2015. All medical wards were above this benchmark during the day and night. For example the average fill rate for ward F7 was 100% during the day and 102% at night and the acute medical unit was 100% during the day and 112% at night.
- The service used the trust escalation procedures if there was a reduction in the number of nursing staff of duty. This included undertaking a risk assessment and escalating the issues to the chief nurse or divisional director.
- Wards allocated at least one qualified nurse and health care support workers to each bay to get to know the patients and provide a constant presence within the bay.
- Nursing handovers were structured and information handed over to the incoming staff included allergies, mobility of patients, incidents and expected date of discharge. Each member of staff on the ward were given a copy of the handover sheet at the beginning of each shift.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for medical admissions and all medical inpatients across all wards. Medical trainees contributed to this rota. The information we reviewed showed medical staffing was appropriate at the time of the inspection.
- There was an on call rota which ensured there was a consultant available 24 hours a day seven days a week for advice and a consultant could get to the hospital within 30 minutes if required.
- The proportion of consultants working in medical services trust-wide was 40% which was higher (better) than the England average of 34%. The proportion of registrars was 30% which was below (worse) the England average of 39%. The proportion of junior doctors was 23% which was higher (better) than the England average of 22%. Middle grade levels were about the same as the England average.
- The total number of medical staff vacancies at the end of November 2015 was 9.69 whole time equivalent doctors. The turnover of medical staff in medical services at the hospital between April 2014 and March 2015 was low apart from diabetes services where it was 22%.
- There were still some medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme.
- The total number of shifts covered by locum medical staff in medical services trust-wide, between April 2014 and March 2015, was variable. However, in the acute

medical unit at the hospital, the average percentage of shifts filled between January 2015 and March 2015 was 30% and in gastroenterology it was 52% during that time.
- This was for a number of reasons including, vacancies, extra staffing over and above the normal levels and extra ward rounds. Locums were either trust staff working extra shifts or from an agency.

Major incident awareness and training

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.

Are medical care services effective?

Requires improvement

We rated medical services as 'Requires Improvement for effective because:

- We found staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment was largely good. However, they did not recognise the principles of the mental capacity act 2005 (MCA)in relation to the use of bedrails and trust documentation was not clear about recording the use of bedrails.
- Staff were not always following trust policy when completing capacity assessments and we found the number of assessments completed for people who lacked capacity was limited.
- The number of staff who had completed the MCA training available was low.
- Patient pain scores were not always being recorded and not all patients were being asked about their pain or supported to manage it.
- Some services, such as diagnostic MRI scans were not provided seven days a week and other services, such as pharmacy were limited at the weekends.
- Recent national audits indicated that although there had been progress the service still needed to make improvements to the care and treatment of people who had chronic obstructive pulmonary disease (COPD).
- Nutrition and fluid intake were not always being recorded correctly.

However,

- Care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits where they were eligible to take part.
- There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients. The service was beginning to monitor compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance with further actions identified.
- The service participated in all of the clinical audits it was eligible for through the advancing quality programme. Where the service was not meeting the appropriate care score target action plans were completed following the clinical audit to address areas identified for improvement. For example an action plan had been put in place to improve the results of the chronic obstructive pulmonary disease.
- Care pathways were in place for managing patients who needed care following a stroke and for patients who received ambulatory care (ambulatory care is medical care provided on an outpatient basis). The ambulatory care pathways included care of patients with cellulitis, pulmonary embolism (PE) and deep vein thrombosis (DVT). The care pathways were based on NICE guidance.
- There were examples of recent local audits that had been completed on the wards. These included documentation and discharge audits. Senior staff said they received the results of the audits and any learning was shared with them via email.

Pain relief

- Pain relief was managed on an individual basis and was not always regularly monitored. Some patients told us they were not consistently asked about their pain and supported to manage it.
- We saw that the level of pain patients were in was recorded on early warning scores documentation. However, if a patient was subject to neurological observations different documentation was used to record early warning scores which did not include the recording of the level of pain. Therefore, it was unclear if patients had been asked about their pain as it was not being recorded on the documentation.
- Services had recently implemented a specialised tool to assess pain in those who had a cognitive impairment such as those living with dementia or a learning disability. However, we did not see any completed assessments in the notes we reviewed of patients who had a cognitive impairment.

Nutrition and hydration

- A coloured tray system was in place to highlight patients that needed assistance with eating and drinking.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal as they were 90not on the ward at the time, staff were able to order a snack for them.
- We saw there was a comprehensive selection of meals available from a menu which was available for patients.
- We observed drinks were available and in reach for all patients. Services used different coloured tops on jugs containing water for patients. This was to denote that water had been changed each morning, afternoon and evening.
- The hospital used the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. An audit of the completion of the tool was undertaken on a weekly basis and in December 2015 there were only 50% accurately completed across the trust. The target was 85%. Actions were in place to improve standards. For example, increasing training for staff and a ward accreditation scheme to be developed to include the focus on nutrition.
- We looked at nutritional assessments for seven patients and found that only one had been fully completed. Only two of the seven fluid balance charts we reviewed in records correctly recorded the total amounts for each patient.
- Staff were aware of the recent patient safety alert for ensuring tubs of dry powder thickener used to thicken patient fluids should not be left in reach of patients. They could describe how they would also highlight this to relatives who may bring in patient's own supply. We also observed that on one of the wards this was stored away from patient areas.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/14 for this trust showed the percentage of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI-a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was better than the national average at 98%. However, only 10% of patients with an N-STEMI were admitted to a cardiology ward which was worse than the England average of 55%.
- The 2013/2014 heart failure audit showed the hospital performed worse than the England average for all four of the clinical (in hospital) indicators and better in five of the eight clinical (discharge) indicators.
- In the 2013 national diabetes inpatient audit (NaDIA) for the hospital was worse than the England average in 13 of the 21 indicators. There was an action plan in place to improve care standards.
- The endoscopy unit had been awarded Joint Advisory Group (JAG) accreditation in March 2015. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. The unit was open six days a week.
- The readmission rates for the hospital during December 2013 and November 2014 t was worse than the England average in gastroenterology, general medicine, non-elective (unplanned) cardiology and respiratory medicine but better than the England average in clinical haematology and elective (planned) cardiology.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures up to January 2016, 83% of nursing and other staff in medical services at the hospital had received their annual appraisal which was below the trust target of 90%. We were told that 12% of

medical staff across the trust had completed their appraisal by August 2015 and 76% were on target to complete their appraisal by the target date of February 2016. However we received no evidence of this.

- The trust did not have a clinical supervision policy. Qualified staff told us there were no formal systems for clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. However, nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.
- Staff confirmed that they had an adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
- There was a preceptorship programme which supported new junior nursing staff. Their competency in undertaking care procedures was assessed by qualified staff.
- The trust was involved in the apprenticeship nursing scheme for nursing and administrative staff with the skills for health academy. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications.
- Medical services ensured that healthcare support workers undertook the care certificate. Nine new ward based healthcare support workers in medical services had begun this qualification. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- We saw that there was a range of specialist nurses, for example a specialist nurse for diabetes and for dementia. Staff told us they knew how to contact these specialists and felt supported by them.
- Staff told us that there were opportunities for development. For example to lead a shift on the ward and a volunteer had attended a dementia awareness course.
- A good example of staff development was seen on the acute medical unit. A practice education facilitator had been employed for the unit and a development plan was in place for all staff. This included ensuring all staff were up to date with mandatory training and training on acute kidney injury in patients.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on the medical wards we visited and wards held MDT meetings which were attended by the ward manager, nursing staff and therapy staff such as a physiotherapist and occupational therapist.
- Staff had access to psychiatric services to provide help and support.
- Meetings about bed availability were held three times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior managers and senior clinical staff.
- Daily ward meetings, called board rounds, were being rolled out across the wards we visited. They reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. These were attended by a range of professionals.
- Ward teams had access to the full range of allied health professionals. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week except for MRI scans which were only available five days a week.
- Consultants were available on site 8am to 10pm Monday to Friday and 9am to 5pm at weekends. There was an on-site registrar 24 hours a day, seven days a week.
- Occupational therapy services were available seven days a week.
- Pharmacy services were available between 9am and 5pm Monday to Friday and between 8am and 12 noon on a Saturday. The pharmacy was available on bank holidays and outside these hours the service was covered by an on call service. Senior staff told us this was having an impact on discharges for take home

medication and there had been occasions when patients had to return the next day for their medication. This was not on directorate risk register but on the pharmacy risk register.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information. Policies, protocols and procedures were kept on the trust's intranet which meant staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.
- MCA training was included in safeguarding training. Information provided by the trust showed compliance rates for level 2 training was 95%. Staff told us that more in-depth MCA training was included in level 3 safeguarding training for specific identified staff above band 6 level. The compliance rate for this training for medical services across the trust was 82%
- Information provided by the trust showed that more in-depth MCA training was available but only 14 members of staff in medical services at the hospital had completed the training.
- Staff were not always following the key principles when using bed rails for patients. Staff on the wards did not know that the use of bed rails can be seen as a form of restraint as outlined in the Royal College of Nursing (RCN) rights, risk and responsibilities guidance. The bed rails assessment did not specifically include the recording of consent or best interest decisions for the use of bed rails. There was however a trust policy that did outline that bedrails could be seen as restraint but the recording of consent and best interest was not outlined for staff.
- Staff knew the principles of consent and we saw written records that indicated consent had been obtained from patients prior to procedures.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. At the time of the inspection, there were no patients with a DoLs authorisation in place on the wards we visited.
- Between April 2014 and March 2015 there had been 10 DoLs applications at the hospital. Overall at trust level the number of applications was 73. This was a significant increase from the previous year which was a trust total of 16 applications. This showed that staff had an increased awareness and understanding of DoLs.
- Staff understanding of the application of capacity assessments to inform decisions about providing care in patient's best interest was variable and there were mixed messages from the trust. Some staff told us they would refer to social services to undertake a capacity assessment and some told us the doctor would complete these. Senior staff said that who completed a capacity assessment would depend on the decision in question. On the discharge unit we saw a poster that told staff that any professional can undertake a capacity assessment. The trust's MCA policy outlined that 'when a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity or consent' .There was also a capacity assessment template for staff to complete contained in the policy. However, the trust DoLs policy outlined that a referral to the local authority to undertake a formal capacity assessment must be made when applying for a DoLs application. Staff appeared to be confused as to who should undertake capacity assessments which meant there was a risk that capacity assessments may not be completed for vulnerable patients.
- We checked four records of patients who lacked capacity and found that none had had a formal capacity assessment recorded.

Are medical care services caring?

Medical care (including older people's care)

Good

We rated medical care services as 'Good' for Caring because:

- Patients told us staff were caring, kind and respected their wishes. People we spoke with during the inspection were involved in their care and aware of when they would be discharged.
- Patients' privacy and dignity was maintained and patients told us that staff were approachable and complimentary about the staff that cared for them. Patients received compassionate care.
- Chaplaincy services were available to provide people with appropriate emotional support.

However,

- We saw staff interactions with people were person-centred; but there was limited interaction with patients on ward F10 and the acute medical unit out of the three ward areas visited.
- Patients were not being fully supported with nutrition and hydration when required.

Compassionate care

- Medical services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect
- Due to treatment being provided at the time of the inspection we were only able to speak with seven relatives and five patients. Patient comments about their care and treatment were variable. Comments included 'most staff are lovely but some staff have an attitude problem and you can wait ages for the call bell to be answered', 'doctors don't always appear to care' 'staff have been brilliant', 'wonderful treatment' and 'treated with respect'. Patients said that staff always introduced themselves.
- We saw that most of the calls bells were answered promptly apart from one on the acute medical unit when we had to alert staff to a patient who required help.
- We observed that during our time on ward F10 and the acute medical unit there was limited interaction between the patients and staff and patients were either in bed or sitting by their bed with no activity taking place. However on the discharge unit we saw a member of staff going through a memory box with a patient which they were enjoying.
- We undertook a short observational framework assessment (SOFI) on F10 and found that whilst there was no negative interactions from staff, there was high dependency and staff stretched at certain periods to meet the needs of patients. For example a patient was very uncomfortable and had to wait for 10 minutes before staff were free to reposition them.
- We observed a meal time on ward F10. During the meal time there was limited presence of nursing staff and we saw that interaction between staff and patients who required assistance with eating and drinking was limited. Of particular concern was a patient who required assistance, which was recorded in their notes, was left with soup and a drink in front of them for 15 minutes without staff helping them. Staff then came with their main meal and took the soup away. They provided help for a limited amount of time, without interaction, before putting the meal down and leaving the patient. We could not see that this patient had a red tray, though we saw these were available on the ward.
- Two sets of relatives said they would come in the next day to help support their relative with their lunch as staff were so busy with other patients.
- We heard of an example where staff had been caring. They had decorated a patient's room and provided cakes at Christmas as they had no relatives to visit them.
- Between November 2014 and October 2015 the friends and family test (FFT) average response rate was 32% which was lower than the England average of 44%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. The lowest response rate was the endoscopy unit with 27% and the highest response rate was wards F9 and F10 with 56%. Over 94% of patients said they would recommend medical services at the hospital.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts for 25 of the 34 areas. These included 'patient given the choice of different types of treatment, 'always given enough privacy when being examined or treated' and 'nurses did not talk in front of them as if they were not there'. The trust fell in the bottom 20% of trusts for 'all staff asked patient what name they preferred to be

called by' and 'family definitely given all information needed to help care at home' However, this was trust-wide and could not be disaggregated specifically for Oldham Hospital
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities. However, this was trust-wide and could not be disaggregated specifically for medical services at Oldham Hospital
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of this and on the wards we visited; they were displayed on a board above the bed.
- Patients said that they were involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said that they felt safe on the ward and had been orientated to the ward area on admission.
- Family members said that they were kept well informed about how their relative was progressing.
- Patients said they had received good information about their condition and treatment.

Emotional support

- We received information from patients and those close to them before the inspection at listening events and through share your experience forms. This told us that there was poor communication between wards which had left patients and family confused about the care being provided.
- Visiting times for the wards met the needs of the friends/ relatives we spoke to. Open visiting times were available if patients needed support from their relatives. Relatives were also able to stay overnight to be with patients who were particularly unwell.
- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to.
- Chaplaincy services were available for patients and relatives if required and there was a multi-faith prayer room at the hospital. The trust also had guidance for staff on religious faith requirements which enabled staff to access to information to support patients

Are medical care services responsive?

Requires improvement

We rated medical service as 'Requires Improvement' for responsive because:

- There was a high number of patients who were moved ward during the night on the acute medical ward and just under half of the patients experienced one or more moves during their stay.
- There was a clear focus on discharge planning with discharge co-ordinators although there were a number of patients experiencing delayed discharge because they were waiting for packages of care and could not be discharged by the hospital until funding had been agreed for this care.
- There were occasions when people had to stay in the discharge lounge overnight and we saw that a patient had not had a regular review by a doctor whilst on the discharge inpatient unit.
- There was also high occupancy levels on the wards and the length of stay for some patients was longer than the England average.
- Complaints took a long time to resolve.

However,

- There were systems in place for the management of patients when there were shortages of beds on medical wards.
- There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patient who had dementia.
- There was access to translation services and leaflets available for patients about the services and the care they were receiving.
- Services took into account the needs of the local people. There were good ambulatory care services and the trust was part of the heathier together programme.

- People were supported to raise a concern or a complaint. Complaints were investigated and lessons learnt were communicated to staff and improvements made.

Service planning and delivery to meet the needs of local people

- The hospital was part of the Greater Manchester health and social care devolution programme to provide a partnership approach to care and the healthier together programme. This was to reconfigure services across Greater Manchester into a small number of specialist centres to help meet the needs of patients
- Medical services had a designated ambulatory care unit. This unit saw patients on an outpatient basis for further tests or follow up assessments to avoid unnecessary admission or a longer stay in hospital. Referrals were from GP's and the accident and emergency department. It was open 8am to 8pm Monday to Friday and 10am to 6pm Saturday and Sunday. However there were times when the service provided by the unit had been reduced due to lack of staff for late shifts. This was not recorded on the monthly staffing reports.
- The facilities and premises in medical care services were appropriate for the services that were planned and delivered.

Access and flow

- Between October 2015 and December 2015, the average occupancy rate on the medical wards at the hospital was 98%. Research has shown that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Between January 2014 and December 2014 hospital episode data (HES) showed the average length of stay for elective medicine at the hospital was 4.7 days which was longer (worse) than the England average. The England average was 3.8 days. For non-elective medicine it was shorter (better) than the England average of 6.8 days.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Between July 2015 and October 2015, data showed there had been 193 outliers at the hospital.
- At the time of our inspection, senior staff told us there were four medical outliers. Patients who were outliers were reviewed on a daily basis by a member of the medical team. We reviewed the records for two medical patients who were outlying on surgical and gynaecology wards, and found they had been seen daily by a member of the medical team. Wards that had outlying patients had contact arrangements for the relevant speciality teams in and out of hours.
- In the period November 2014 to October 2015, 48% of patients experienced multiple ward moves during their stay. This was the same as the previous year.
- Information provided by the trust showed that between April 2015 and September 2015, the number of patients on medical wards that were transferred to another ward after 10pm at night was relatively low except for the acute medical ward. The average number of moves was 105 a month. The information showing the reasons why these moves had taken place during the night was not available. Staff told us delayed discharges on the wards and beds not being identified as being available until late in the day had an impact on the number of moves at night.
- The hospital held a bed management meeting at 8.30am each morning. Information gathered during the day determined if another meeting was required in the afternoon. Bed managers supported these meetings by providing up to date information to plan bed capacity and respond to acute bed availability pressures.
- There was a clear focus on effective discharge planning for patients and wards. Staff discussed discharges at the daily board round on the wards involved in the pilot and at the bed management meeting. Discharge letters were sent to GPs' and patients were given a copy.
- There was a discharge team who supported patient discharges that were complex or required rapid discharge. Discharge co-ordinators were allocated to medical wards to support the process.
- Hospital episode statistics showed that discharges at the trust were often delayed due to waiting for care packages, completion of care assessment or for equipment that was needed in the home. This was in line with similar organisations in the region. The trust were working with partner organisations to ensure that patients were discharged as soon as possible.
- To support this the trust had access to community beds in care homes which were used for patients who were fit

for discharge but were waiting for care packages or equipment to be put in place. A hospital discharge co-ordinator supported the patient and their family whilst in the community bed.

- The hospital had a discharge unit which consisted of a discharge lounge and a 20 bedded inpatient area. Both areas were open 24 hours a day seven days a week. The inpatient unit was for up to nine beds for rehabilitation patients who still required multidisciplinary input and could stay up to 14 days. Patients were reviewed twice a week by a doctor but we did see that for one patient this had not happened. This was raised with the manager who assured us they would look into this.
- There was an additional 11 beds for medically fit patients ready for discharge. The reasons for the delay were due to care packages or further social assessments. The average length of stay for these patients was between four to seven days. These patients were not reviewed on a daily basis by a doctor but staff knew how to contact a doctor should a patient deteriorate.
- There had been seven occasions in the last 12 months when patients from the emergency department or the acute medical unit had been in the discharge lounge overnight. There were two beds available in the discharge lounge. Patients had access to the facilities of the discharge unit and food was available. Staff had access to the on call consultant should a patient deteriorate.
- The total number of patients who had used the discharge lounge between February 2015 and January 2016 was 3605.
- Delayed discharges were identified as an area of risk in medical services and was on the risk register with actions identified to mitigate the risk. These included a discharge training package to be developed for ward teams and representation at the trust service improvement work stream looking at discharges. However, the specific risk of patients staying overnight in the discharge lounge was not highlighted on the directorate risk register.
- Services were working with local authorities to identify a system of a single social care assessor to assess patients for community care funding in each locality within the division. The timeframe for implementation of this system was March 2016.
- Staff told us there had been occasions when 16-18 year old patients had been admitted to the acute medical unit due to insufficient beds on the paediatric wards. A safeguarding referral was submitted to the safeguarding team each time this happened. Between February 2015 and January 2016 there had been 127 patients admitted. A matron visited any 16-17 on an adult ward daily.
- During November 2014 and October 2015 referral to treatment times (RTT) for all medical specialities including cardiology and gastroenterology were above the England average and the trust target of above 92%. General medicine and geriatric medicine were 100% compliant with the 18 week RRT.
- The above figures have been provided by the trust at the time of the inspection; however we have subsequently learnt these may be unreliable and are therefore not assured that performance is at this level. We are now working with Trust to validate this information and follow up any actions arising
- Medical wards had been included in the initiative looking at the perfect week for patients during June and July 2015. This is an approach for trusts to look at challenges in meeting standards. This included ensuring that patients had a senior review before 10am, to achieve 50% of discharges earlier in the day and increase the number of discharges from the acute medical unit to improve the flow of patients. Medical wards at the hospital did not meet three of the seven standards; however, actions were in place to improve the flow of patients through the hospital such as improving communication between discharge teams and ward staff.

Meeting people's individual needs

- The trust used a leaf symbol to indicate that a patient was frail or elderly and a butterfly symbol to indicate that a patient was subject to end of life care. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- The hospital had implemented the 'forget-me-not' scheme. This was a discreet flower symbol used as a visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.

Medical care (including older people's care)

- There was a specialist nurse, who was the clinical lead for dementia, who provided support for staff and a central point for queries. The trust also had access to a psychiatric liaison team who saw and assessed patients with a cognitive impairment.
- A new flagging system for people living with cognitive impairment (including dementia) began in October 2015 as part of the electronic patient record. When a patient scored below seven on the mental test an alert was automatically sent to the safeguarding team.
- All the wards we visited had dementia friendly signage on bays and bedrooms, paintwork and flooring. Toilet and shower areas were clearly signed and toilet seats were in a contrasting colour. There were memory boxes available for staff to use with patients and staff knitted 'twiddle muffs' for patients so they had something to occupy their hands. Twiddle muffs provide a source of visual, tactile and sensory stimulation for people living with dementia.
- The discharge unit had a dementia garden. The garden gave patients, their families and their carers the chance to share experiences in a relaxed, safe and informal setting surrounded by sights from days gone by.
- The service has a dementia strategy covering three years from 2015 to 2018. It included key objectives such as early diagnosis and improved quality of care. It outlined how the objectives would be met and measured.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
- Care plans we saw were not always person-centred to identify individual needs but did contain the necessary information to ensure that patients were not at risk.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint and leaflets were available in all areas. Notice boards within the clinical areas included information about the number of complaints and any comments for improvement.
- The trust recorded complaints electronically on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Ward managers told us how they were working to achieve 'on the spot' resolutions of concerns where possible.
- Information provided by the service showed that there had been 47 complaints raised across medical services at the hospital between December 2014 and December 2015. The highest number of complaints were regarding clinical treatment. On average it took 131 days to resolve the complaint. However, three complaints took over 300 days to resolve.
- Examples of learning from complaints included staff ensuring they were documenting conversations with patients and family and to be aware of the impact on people when speaking with them. Following a complaint booking clerk had been employed on the discharge unit to help ensure transport was available when required.
- Complaints were discussed at governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us managers discussed information about complaints during staff meetings to facilitate learning.

Are medical care services well-led?

Good

We rated medical services as 'Good' for well-led because:

- Medical care services were generally well led with evidence of effective communication within staff teams. The visibility of senior management was good and there were information boards to highlight each ward's performance displayed on each ward area. There was no specific strategy for medical services but there was full engagement in the trust overall strategy and plans.
- Staff felt supported and able to speak up if they had concerns and the number of staff who felt valued was higher than the England average. Medical services

captured views of people who used the services with learning highlighted to make changes to the care provided. People would recommend the hospital to friends or a relative.
- There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital

However,

- There was a clear governance structure but there was limited evidence of learning discussed at key meetings
- Risk registers were in place and had actions identified, however, there were risk which had been on the risk register since 2011 with actions still to be completed. This meant risk might not being managed in a timely way. Similarly there were actions put the risk register with the date of identification being after the time of the inspection.

Vision and strategy for this service

- The trust's vision was to be a leading provider of joined up healthcare that would support every person who needed services, whether in be in or out of hospital, to achieve their fullest health potential. The values were to be quality driven, responsible and compassionate. Staff were aware of the vision and values and they were displayed on the notice boards.
- The Trust's strategic objectives were based on the vision and these objectives cascaded down to service and individual objectives for staff.
- The trust had a service development strategy for 2015-2020 which included medical services. This outlined plans for the next five years which linked to the healthier together programme.
- There was no specific strategy or business plan for medical services but they contributed to the trust strategy and development plans to improve services.
- NHS staff survey results for 2015 showed that 76% of staff in medical services trust-wide said they had clear planned objectives. This was about the same as the trust average of 80%. The number of responses was 250.

Governance, risk management and quality measurement

- There was a new risk management strategy being implemented in the trust at the time of the inspection. Medical services had an overall risk register with each directorate having its own risk register.
- The divisional risk register highlighted risks across all medical services at the trust and actions were in place to address concerns, for example lack of staff and slips, trips and falls by patients and visitors. Each action had a target date for completion of the action. However, from the information provided by the trust it was not clear if there was a review date for each risk and some risks had been on the risk register since 2011. This meant it was not clear whether all risks were being managed in a timely way.
- Each hospital medical directorate had an additional risk register. The directorate risk register for medical services at the hospital was relatively new and risks highlighted had only been on the register since January 2016. However, some of the risks had the identified date as March 2016, which was after the inspection date when the risk register was shown to us. This meant it was not clear when risks had first been identified.
- Staff at all levels knew that there was a risk register and senior managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services. The divisional quality and performance meeting for medical services was held on a monthly basis. As part of the meeting, there was a review of items to celebrate good practice and items of concern.
- It was clear from the minutes we reviewed that the risks, incidents and complaints were reviewed and discussed. However there was limited evidence of how learning that had taken place was to be shared with staff apart from learning from complaints. Actions from the meeting were identified in the minutes along with the person responsible but not always the target date for the actions to be completed. It was therefore difficult to track what progress had been made against agreed actions.
- On a quarterly basis the division held confirm and challenge meetings to discuss performance such as serious incidents, staffing and service developments. From the minutes we reviewed key themes were identified and actions, however, it was not clear how these actions were going to be monitored. This meant it was unclear how improvements were going to be made.

Medical care (including older people's care)

- Senior staff were able to tell us how their ward's performance was monitored, and how performance reports were used to display current information about the staffing levels and risk factors for the ward.

Leadership of service

- Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said morale was good.
- In the 2015 staff survey, 94% of staff in medical services said they were enthusiastic about their job and 87% looked forward to going to work. This was better than the England average of 57%. 87% of staff said that medical services acted fairly with regard to career progression, regardless of ethnic background, gender, religion, sexual orientation, disability or age.
- The latest staff friends and family test results for January 2016, show that 70% of staff would recommend the hospital as a place to be treated. 57% of staff would recommend the hospital as a place to work.

Public engagement

- The trust carried out their own inpatient satisfaction survey around food at the hospital. This included medical wards. Questions included being able to choose their own meal and if they had any problems with their food during their stay. From the results we reviewed, in October 2015 the hospital was meeting the overall performance indicator of 98%.
- This hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. At the time of the inspection, 94% of patients would recommend the wards at the hospital to friends or a relative.
- There were comments boxes on the ward for patients and public to leave comments and suggestions. On each ward there was a 'you said, we did' board which highlighted changes that had been made following comments.

Staff engagement

- The trust celebrated the achievements of staff at an annual event. At the last event medical services had had a number of staff nominated for their work at the trust.
- The trust distributed regular 'Monday morning' emails informing staff of new news for the trust and senior staff told us it welcomed staff to discuss any issues or ideas. However 44% of staff in medical services felt that managers did not act on staff feedback.
- In March 2015 staff in the medical division contributed to the on-line workshop to say how the trust could improve staff health and wellbeing and reduce staff sickness and absence. Between September 2014 and September 2015 staff sickness levels in medical services was higher than the division target at 6.8%.
- Staff participated in the 2015 NHS staff survey. This included questions such as how staff felt about the organisation and their personal development. 92% off staff in medical services trust wide felt the training and development they had undertaken had helped them to deliver a better patient experience and 94% felt it had helped them to do the job more effectively. 89% felt that they were valued by managers which was better than the England average of 69%.

Innovation, improvement and sustainability

- The service had recently introduced the senior person's resilience and independence team (SPRINT) with the aim of reducing admissions to the accident and emergency department for frail older people. This involved working closely with partner organisations such as Age UK, primary care and social care.
- An analysis of the 2015 NHS staff survey results showed 86% of staff in medical services trust wide, who responded, felt they were able to make suggestions to improve the work of their team/department. This was better than the national average of 74%
- The survey also showed that 86% of staff said they had frequent opportunities to show initiative in their role.

Medical care (including older people's care)

66% of staff said they were involved in deciding on changes to improve services for patients. This was worse than the trust average of 71% but better than the England average of 51%.

- Medical services were planning to have pharmacy technicians permanently based on the wards to undertake medication rounds. This aimed to reduce the number of medication errors and more robust medication audits.

Surgery

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

Information about the service

Surgical services are provided under the surgery and anaesthesia clinical group across four sites by Pennine Acute Hospitals NHS trust. The Royal Oldham hospital carries out a range of surgical services including, trauma and orthopaedics, urology, vascular surgery, colorectal surgery and general surgery. Hospital episode statistics data showed 13,200 procedures were completed in the year July 2014 to June 2015; of which 58% were emergency surgical procedures, 23% were day surgery cases and 19% were elective surgery procedures.

As part of the inspection, we inspected the eight main theatres, Ward T3 (vascular surgery), Ward T4 (surgical triage and elective general surgery), Ward T5 (colorectal), Ward T6 (general surgical admissions unit), Ward T7 (trauma and orthopaedics) and the pre-operative assessment unit.

We spoke with 13 patients and carers and looked at 10 patient care records. We spoke with 16 staff of different grades including nurses, doctors, allied health professionals, domestics, support workers, surgeons, administrators and matrons. We received comments from our listening events and from people who contacted us to tell us about their experiences. We observed care and treatment, reviewed performance and assessed information about the surgery services. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

Summary of findings

We rated surgery as requires improvement overall because:

- Staffing levels were low at times. There was a high nurse staffing vacancy rate and high levels of sickness. This meant that on occasions staffing was only 85% of the required level.
- The early warning system the hospital had adopted was implemented inconsistently and clear procedures for escalate concerns for a deteriorating patient were not embedded.
- The division did not correctly undertake assessments of mental capacity and consent to treatment in all cases. We saw evidence of failure to do this in two patients where they were treated as having no capacity without assessment and documentation of the background, considerations and determinations to reach that decision. This was contrary to the Mental Capacity Act 2005 legislation.
- The service was non-compliant with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients.
- The service had very high readmission rates, which were significantly higher (worse) than the England average.
- There were issues with the documentation of 'do not attempt cardiopulmonary resuscitation (DNACPR).

However, we also found;

Surgery

- There was a good culture of reporting incidents and safety issues and investigations were thorough. We saw evidence of learning when things went wrong and saw implementation of measures to improve quality and safety.
- The service was compliant with the World Health Organisation (WHO) checklist and National Patient Safety Agency (NPSA) 'five step to safer surgery' operating procedures.
- The environment was clean and hygienic with low levels of healthcare associated infections.
- Care was otherwise planned and delivered in line with evidence based guidance and best practice. Patient outcomes were good and in some areas the division performed better than other trusts and England averages.
- Multidisciplinary team working was good with satisfactory access to a range of specialities. Staff were experienced and competent and had the skills to undertake their job effectively.
- Staff went about their work with a caring and compassionate nature. They protected their privacy and dignity of their patients when providing care and treatment. Patients told us staff were kind and respectful and that they were kept informed and involved in the care and treatment they received. This was reflected by the good friends and family test results the division received; which were better than the England average.
- The hospital met the national target time of 18 weeks between referral and treatment for 95.6% of their patients.
- There was attention to individual patient needs and support for those with complex needs. The ward environment was very good for dementia patients and there was implementation of many of the recommendations from dementia best practice guidance.
- Complaints were handled and responded to appropriately and the feedback was used to improve services for patients.
- Theatre utilisation was good and the division made good use of the resources and time available to them. Bed occupancy was optimum and we saw that patients had good access to treatment and their care was planned and delivered and flowed well from admission to discharge. Hospital lengths of stay for surgical patients at Fairfield were similar to the England average.
- The surgery and anaesthesia division was well led both on a ward level and at divisional level. Managers were competent and enthusiastic about their service and there appeared to be a positive supportive culture throughout the wards and departments. Staff felt supported and there was good team working and support at all levels. Staff were fully aware of the strategy and direction of trust and their role in that vision, they saw positive changes in the last 12 months and were optimistic about the future.

Surgery

Are surgery services safe?

Requires improvement

We rated this service as requires improvement for safe because:

- Staffing levels were low at times and there was a high nurse staffing vacancy rate and high levels of sickness. This meant that on occasions staffing was only 85% of the required level.
- The early warning system the hospital had adopted was implemented inconsistently and clear procedures for escalate concerns for a deteriorating patient were not embedded.
- The recording of the wasting and disposal of controlled drugs, when the full contents of a vial was not prescribed was not compliant with trust policy and The Royal Pharmaceutical Society of Great Britain (RPSGB) guidance 'The Safe and Secure Handling of Medicines' (2005).
- There were issues with the documentation of 'do not attempt cardiopulmonary resuscitation (DNACPR).

However;

- There was a good culture of reporting incidents and safety issues and investigations were thorough. We saw evidence of learning when things went wrong and saw implementation of measures to improve quality and safety.
- Surgery was compliant with the World Health Organisation (WHO) checklist and National Patient Safety Agency (NPSA) 'five step to safer surgery' operating procedures.
- There were high levels of compliance with safeguarding and mandatory training.
- The environment was clean and hygienic with low levels of healthcare associated infections.

Incidents

- There were no 'never events' for the period December 2014 to December 2015. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The anaesthesia and surgical division at Oldham reported over 1036 incidents in the year December 2014 to November 2015. The majority of these resulted in no harm, low harm or were 'near misses'. 65 incidents were recorded as having caused moderate to severe harm to a patient and involved falls, medication errors, equipment issues, delays in diagnosis and treatment, patients' development of clostridium difficile (C.diff) pulmonary embolism, deep vein thrombosis (DVT) and pressure ulcers, eight resulted in more serious harm.
- Four serious untoward incidents were reported at Oldham surgery in the last three months these were two delays in diagnosis, one delay in treatment and one health care acquired clostridium difficile infection. These were reported via the STEIS system appropriately.
- We found that the Trust conducted appropriate investigations into such incidents using a 'root cause analysis' style of investigation. We found that these were conducted by appropriately experienced and skilled staff at a senior level. We also found that the results of these investigation and areas to improve safety and learned were shared with staff of all levels. This was done through newsletters, team briefings and safety huddles, notice boards displays and emails. We saw examples of practical changes and learning in response to such incidents. Incidents were also discussed in the 'pride in safety' newsletters.
- Representatives from the surgery and anaesthesia division investigated and discussed deaths and poor surgical outcomes at their regular mortality and morbidity meetings. Areas for improvement and learning were highlighted and recommendations for changes to practice were made, which were circulated appropriately to improve performance.
- The clinical group he surgical division were familiar with the 'Duty of Candour' procedures and processes. The 'Duty of Candour' is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. We saw examples of the 'duty of candour' being implemented appropriately following harm caused to a patient. We found the process was in line with trust policy and national guidance. Patients and relatives were involved in the process and were offered the chance to speak with senior staff.

Safety thermometer

Surgery

- The NHS Safety Thermometer is an assessment tool, which measures a snapshot of harms which may have occurred during the month (such as falls, pressure ulcers, bloods clots, and catheter related urinary infections).
- During our visit we found that safety thermometer information was displayed on entrance to each ward and was visible to patients and visitors entering the ward.
- Each ward used the results of the safety thermometer to plan areas of focus for quality improvements; they also used it to benchmark themselves against other wards and departments.
- The trust's December 2015 'Integrated Performance Report' confirmed that the highest priority trust wide harms were pressure ulcers and falls. A pressure ulcer reduction action plan was in place within the Oldham surgery and anaesthesia division and they focussed on falls reduction through their participation in the trust safety programme.
- Information provided to Health and Social Care Information Centre showed that from January to December 2015 the trust reported 94.5% harm free care, this is similar to the England average of 94.1%.

Cleanliness, infection control and hygiene

- Infection control policies and procedures were available and accessible to staff and the staff we spoke with were familiar with those policies and where to seek advice if they needed to.
- During our visit, we found the environment to be visibly clean and hygienic; we saw that there were effective cleaning regimes in place and that they were audited monthly.
- We observed staff following hand hygiene procedures and using appropriate protective personal equipment (PPE), such as gloves and aprons, when delivering care.
- We observed theatre staff to follow appropriate infection control protocols and gowning procedures were adhered to in theatre areas.
- The majority of staff followed 'bare below the elbow' guidance; however we observed that a senior nurse was not in uniform and was not 'bare below the elbows' whilst working in a clinical area. This was a breach of the Trust's own policy.
- Most the clinical areas were free from clutter and items were appropriately stored. Some wards had been through the trusts 'well organised ward' (WOW) programme, which streamlined wards and freed up space by removing unnecessary items. However, two wards appeared cluttered around the nurses' stations caused by storage of patient record trolleys and pieces of equipment. This made the thoroughfare narrow and hindered the passage of trolleys and equipment.
- Trust audit data showed surgical wards achieved 100% compliance with infection control policy compliance, facilitated hand hygiene and commode cleanliness; 98.4% compliant with PPE use; 95.6% for observed hand hygiene and 87.5% compliant with C.Diff precautions.
- The Trust as a whole had six cases of MRSA infection, 59 cases of clostridium difficile infection from February 2015 to January 2016. The trust were not able to advise which specific areas they related to.
- Ward and theatre managers undertook regular audits to monitor compliance against key trust infection control policies such as hand hygiene, use of PPE, isolation precautions.
- The surgery and anaesthesia division at Oldham reported similar or lower surgical site infection (SSI) rates across all specialities compared to the England average for the last 5 years. However, infections in colorectal operations were slightly higher than the England average. In the latest surgical site infections report the orthopaedic surgery department reported zero infections in 63 knee replacement operations which was better than the England average; one infection in 115 hip replacement operations which was better than the England average and six infections from 248 neck of femur repair operations; which was worse than the England average.

Environment and equipment

- Equipment such as commodes and hoists were visibly clean and appeared well maintained.
- Waste and clinical specimens were handled and disposed of appropriately. This included safe sorting, storage, labelling and handling.
- The division used Electro-biomedical Engineering (EBME) to maintain and check all their equipment. Stickers were in place to show checks were up to date.
- The trust used single-use, sterile instruments as appropriate and those we checked were within their expiry dates. The service had on site arrangements for the sterilisation of reusable surgical instruments and could secure a one hour return of urgent items if necessary.

- Staff in the theatres stated they always had access to the instruments and equipment they required and confirmed if any equipment was faulty that it was repaired or replaced promptly. There was sufficient storage space in the theatres and items such as surgical procedure packs were appropriately stored in a tidy and well organised manner.
- Bariatric equipment was available to the wards and theatres from central storage if required.
- The waiting rooms for patients in the surgical admissions area were appropriate, they were clean, tidy, equipped with a television and comfortable seating.
- We found that emergency trolleys were available and accessible, were checked and maintained in line with trust procedures. However, we found an inconsistent approach to the recording of unique reference seal numbers, in some areas numbers they were not recorded. This was against trust policy and may mean that any tampering with the trolley may not be evident.

Medicines

- During our inspection, we found that medicines, including controlled drugs and intravenous (IV) fluids were stored safely and in line with agreed protocols.
- We saw that staff carried out and recorded daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. We checked a sample of controlled drugs and found the stock balances correlated with the registers. We also saw that two staff members had signed for controlled drugs.
- However, we saw an inconsistent approach to the recording the wasting and disposal of controlled drugs, when the full contents of a vial was not prescribed. That is even within the same ward, on some occasions the section in the book was completed and on other occasions it was not completed. This was not in keeping with Trust policy and The Royal Pharmaceutical Society of Great Britain (RPSGB) guidance 'The Safe and Secure Handling of Medicines' (2005).
- We found that medicines requiring cool storage were stored appropriately and records showed that refrigerators were checked daily to ensure they were at the correct temperature.
- A pharmacist was available daily Monday to Friday and via an on call system at weekends, the pharmacist reviewed prescriptions and records and ensured medicines were available.
- Patients' drug allergies were clearly recorded on notes, above their bed space and such patients wore a red wristband to highlight this.

Records

- During our inspection, we checked documentation relating to 'do not attempt cardiopulmonary resuscitation (DNACPR). We found that of four we checked two were incorrect. The documentation had not been completed properly and the correct procedures had not been followed. These issues were consistent with errors noted during a trust audit in November 2014. This issue was brought to the attention of the nurse in charge and the Trust board, who took action to deal with this matter.
- Nursing and medical information was available electronically and though paper records. As part of our inspection, we reviewed the records of 10 patients and on the whole we found these to be accurate, complete, legible and up to date.
- The records contained the relevant patient history, patient allergy status, relevant information and applicable risk assessments. We saw care plans and pathways were completed thoroughly in nursing notes and these were completed before, during and after surgery.
- We saw that there was a good system for pre-operative assessment, which followed an effective process to assess and highlight individual patient needs. Integrated care pathways were commenced at pre-operative clinic for certain procedures.
- Patients' records were stored in lockable trolleys, which kept their personal information safe.
- Only one operation was cancelled due to a failure to obtain patients records in January 2016. This was from a total of 364 operations that month.

Safeguarding

- The surgical and anaesthesia division was 99% compliance with mandatory safeguarding training.
- Staff were aware of their responsibilities regarding safeguarding and were familiar with the process to follow; they could describe how to access the policy on the trust intranet and who to speak to for advice.
- Staff received training and annual updates, the level of training depended on their role and grade.

- Surgical staff had access to the hospital specialist safeguarding nurses who were available advice and information, outside of core hours, the hospital coordinator or matron bleep holder was available for advice.
- There was evidence that the procedures were being followed and that multidisciplinary team meeting were held to discuss the best interests and safety of patients.

Mandatory training

- Staff received mandatory training in areas such as basic life support, moving and handling, fire safety, health and safety, equality and diversity, information governance and infection control. This was updated annually by attendance on training courses or by training done remotely on a computer.
- Compliance with mandatory training and updates was 97.7% for the surgery and anaesthesia division at Oldham.

Assessing and responding to patient risk

- The surgery and analgesia division used an early warning score (EWS) system to identify patients at risk of deterioration. However, the document they used to record observations and scores was a traditional observation form. There was no colour coding system which dictated immediate action; it was necessary that the form be cross referenced with a trust algorithm to determine trigger scores and subsequent action. It was not clear from documentation that if a patient scored eight on the EWS, that they would be treated any more urgently than if they scored a three. This uncertainty was supported by the division's own monthly EWS audit data which showed inconsistency and non-compliance with escalation procedures and correct regularity of observations.
- During our inspection, we observed theatre teams undertaking the National Patient Safety Agency's (NPSA) 'five steps to safer surgery' procedures and the World Health Organisation (WHO) checklist. Staff completed safety checks before, during and after surgery and demonstrated a good understanding of these safer surgery guidelines.
- NPSA steps and the WHO checklist data was audited monthly and records of compliance were kept. Data from January to November 2015 showed 97.6% compliance with WHO briefings, 99.8% compliance with NPSA steps and 100% compliance with WHO debriefings.
- The theatre manager also monitored compliance by undertaking spot checks and highlighting inconsistencies.
- Patients were assessed for their risk prior to surgery through assessment of patient risk factors for surgery, which is in keeping with best practice recommendations by the Royal College of Surgeons. This was done through assessing comorbid conditions, past medical history and lifestyle issues along with tests and examinations. This was assessed at pre-operative assessment clinics where possible and upon admission for emergency or other cases.
- A critical care outreach team was available to attend to sick and deteriorating patients on the surgical wards. However, this service did not provide 24 hours cover. Cover outside of these times was provided by out of hours bleep holders who responded to emergency calls.
- Acutely sick patients from around the hospital, including medical patients were sometimes cared for in the recovery area in theatres. This was if no bed available in the critical care areas. This happened on 4 occasions in January 2016. Data showed that patients stayed in recovery for about 6 hours, before being transferred to critical care.
- A 24 hour telephone number was provided to patients upon discharge from the wards, this gave advice on what to do and who to contact if patients or relatives were concerned following discharge.

Nursing staffing

- The number of staff required for each ward was determined by the use of the 'Safer Care Nursing Tool' (SCNT), which is a recognised nursing acuity tool and is endorsed by the National Institute for Health and Care Excellence (NICE). This was audited every six months and was last completed in November 2015.
- During our visit, the wards had sufficient numbers of trained nurses and support staff on duty with an appropriate mix of skills. However, staffing figures for January 2016 showed mixed results, on average one surgical ward (Ward T6) had at only 85% of their allocated establishment of registered nurses on duty during the day in January 2016. Across all surgical wards on average, there were 88.7% of registered nurses and

97.4% of care staff on duty during the day. At night on average, there was an acceptable level of staff as there was always at least 93% of registered nurses and 100% of care staff on duty in January 2016.

- Registered nursing vacancies for surgical specialities at Oldham were 10.54% in December 2015, we were advised that the majority had been recruited to, but staff had not started yet.
- Sickness rates for registered nurses in surgical specialities was 6.4%, for other clinical staff which included care workers this was 8.17%.
- Gaps in the rota were filled with hospital bank shifts and external agency staff. There was high use of agency staff in theatres, which was recorded as 9.3% for January 2016 but was 12.58 for December 2015. Even with these staff, a review of staffing levels showed that staffing establishments were not always maintained.
- Given these issues, we were not to satisfied that there was enough nursing staff available at all times to ensure that a safe level of care was provided to patients.
- The planned and actual staffing levels for the day's shifts were displayed on notice boards in each area we inspected.
- Agency and bank staff received an induction and orientation to the area they were working and agency staff were often 'block booked' to specific area, particularly in theatres.
- Nursing staff handovers occurred during shift changes and included discussions about patient needs, safety concerns and staff allocation.
- Theatres were staffed greater than Association for Perioperative Practice (AfPP) minimum staffing standards.

Surgical staffing

- Surgical wards had a daily consultant led ward round including weekends.
- Consultants were accessible by telephone for advice and support when not physically on site, such as evenings and weekends and operated a rotational on call system for out of hours periods.
- Daily medical handovers took place during shift changes. These included discussions about specific patient needs and highlighted the sickest patients and those with potential for deterioration.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. Such staff were provided with local inductions to ensure they understood the hospital's policies and procedures.
- There was a high reliance on locum doctors within the division though most were on long term assignments with the trust.
- Trust data shows they had vacancies for 5.3 doctors in the surgery and anaesthesia division as of December 2015; this was 4.3% of the total doctors staffing. The sickness rate for doctors was just 1.26%, which was similar to the England average rates.

Major incident awareness and training

- There was a documented 'major incident plan for the Oldham hospital site', a 'service continuity policy and strategy' and a 'crisis management plan' for dealing with major incidents and emergencies such as terrorist threats, flood, fire or process management failures.
- The anaesthesia and surgery division had a designated function as part of their role into the hospitals major incident plan.
- All staff received emergency training on their corporate induction training days.
- Fire and bomb training was updated annually as part of the mandatory training package.
- Emergency evacuation tests were conducted periodically on site.
- Protocols were in place to defer elective surgical activity in order to prioritise unscheduled emergency procedures. There is also a seven day, 24 hour emergency theatre in operation under the CEPOD arrangements.

Are surgery services effective?

Requires improvement

We rated this service as requires improvement for effective because:

- The division did not correctly undertake assessments of mental capacity and consent to treatment in all cases.
- We saw evidence of failure to comply with the requirement of the Mental Capacity Act 2005 requirements in two separate cases. Two patients were treated as having no capacity without any assessment

and documentation of the background, considerations and determinations to reach that decision. Treatment was then carried out without their involvement and they were afforded no input into decisions about their care.
- The division was non-compliant with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients.
- The hospital did not meet the requirements of some British Orthopaedic Association standards for Trauma (BOAST) standards, which meant patients waited longer than recommended for surgery for fractured neck of femur and for trauma injuries to upper limbs.
- Furthermore, the division had very high readmission rates, which were significantly higher (worse) than the England average.

However;

- Care was otherwise planned and delivered in line with evidence based guidance and best practice. There attention to the pain control needs of patients and their nutrition and hydration needs were met.
- Patient outcomes were good and in some areas the division performed better than other trusts and England averages.
- Multidisciplinary team working was good with satisfactory access to a range of specialities.

Evidence-based care and treatment

- The surgery and anaesthesia division used national guidance and best practice in their care and treat of patients. They monitored their own compliance against National Institute for Health and Care Excellence (NICE) standards.
- Emergency and unplanned surgery was undertaken in accordance with the national confidential enquiries into patient outcome and death (NCEPOD) and the 'standards for emergency care' recommendations by the Royal College of Surgeons (RCS).
- Care pathways followed relevant guidance including hip fracture, surgical site infection, and VTE best practice.
- The division followed NICE CG50 guidance but there appeared to be some inconsistencies in their application of the early warning system.
- There was non-compliance with a number of elements of the NICE clinical guidance 83 concerning the rehabilitation of critically ill patients. This was because the outreach service did not cover all wards and did not provide continuing care and monitoring of patients who had spent time in critical care. The trust had conducted a 'gap analysis' and accepted that there were gaps in the service but had not formed a plan of action to deal with them at the time of our inspection.
- The British Orthopaedic Association 'standards for trauma' (BOAST) recommend that patients with a fractured neck of femur should have reparative surgery within 36 hours of presentation. From April 2015 to January 2016, Oldham met this target in 64.3% of patients on average across those months. This meant that 35.7% of patients, that is one in three patients failed to have their surgery within the recommended timeframe. Non-compliance with this recommendation is associated with increases the mortality and morbidity outcomes in such patients. Failure to achieve this recommendation has been an issue for some time and the division has not succeeded in addressing these issues despite being highlighted several times over the last year and issues being discussed at quality and governance meetings.
- The division also failed to achieve compliance with other best practice tariffs for fractured neck of femur patients in 46.3% of patients according to the national hip fracture audit from April 2015 to January 2016.
- Staff told us that there were issues with delays in fracture clinic which resulted in delays for surgical patients receiving their operations. This view was supported by complaints from patients regarding delays in the fracture clinic and by incident reports by staff. This delay in receiving corrective surgery was supported by evidence that between March 2015 and February 2016, 76.6% of patients who were referred to fracture clinic with suspected upper limb fractures from the A&E department were not seen in clinic within 72 hours, which was the recommendation within the British Orthopaedic Association standards for Trauma (BOAST) standards.
- Enhanced recovery pathways were used in a some orthopaedic surgical procedures, enhanced recovery is an evidence-based approach to care that helps people recover more quickly after having major surgery; this reduced the length of stay for patients and has resulted in much shorter stays in hospital than the England average for these patients.
- The division undertook local audit activity this included areas such as record keeping audits, anaesthetic record keeping audits, EWS audits, delays in treatment audits.

- Staff told us policies and procedures reflected current best practice guidance and available electronically on the trust's intranet. We reviewed a selection of policies, which were up to date and consistent with national guidelines.

Pain relief

- The hospital has a dedicated specialist pain team which operated Monday to Friday during core times. Outside of this period advice and input was available from the on call anaesthetist.
- The division was compliant with some but not all the recommendations of the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- Patients were assessed at pre-operative clinic for issues relating to pain and their preferred method of pain relief. Potential issues or concerns were highlighted before the patient attended for their procedure.
- Staff used pain scores to assess and monitor pain as part of the patients' regular observations.
- The majority of patients said they received pain relief medication when they needed it, although there were some reports of delays in receiving medication.

Nutrition and hydration

- A variety of food choices was available to patients. Special diets, for example diabetic, gluten free, renal, soft textured and allergy diets were available.
- Patient were weighed on admission and received assessments of their nutritional requirements, which highlighted if they were at risk of dehydration or malnutrition.
- Fluid and food charts were updated and reviewed regularly. Records showed regular dietician involvement with patients who were identified with low intake or at high risk of dehydration and or malnutrition.
- The hospital used the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. A trust wide audit of the completion of the tool was undertaken in December 2015 which found just 50% of assessments were accurately completed against a target of 85%. An action plan was put in place to improve standards. This included increased training for staff and the ward accreditation scheme had been developed to include a focus on nutrition.
- Patients with difficulties eating and drinking independently were highlighted, given special diets if necessary and were provided with support and assistance with eating and drinking as necessary.
- Patients told us they were happy with the choice of food and drink offered to them.
- The division had adopted a three coloured water jug system, this worked by using a different coloured jug for the morning, afternoon and evening, this ensured that patients visible assurance that patients had a fresh supply of water at least three times a day.

Patient outcomes

- Hospital episode statistics data showed 13,200 procedures were completed in the year Jul 2014 to Jun 2015; of which 58% were emergency surgical procedures, 23% were day surgery cases and 19% were elective surgery procedures.
- The national hip fracture audit report 2015 showed that 66.2% of patients at Oldham hospital had surgery on the day of admission or the following day, which was recommended by NICE guidance and the British Orthopaedic Association Standards for Trauma. This trend continued and latest figures showed that from April 2015 to January 2016 this dropped to 64.3% of patients having their surgery within the recommended 36 hour target. This meant that one in three patients waited longer than recommended for their surgery.
- Oldham performed worse than the England and region averages for overall outcomes in the hip fracture audit, but performed well on some measures such as mobilising out of bed the day following surgery, medical assessment following surgery and shorter than average length of stays.
- The emergency laparotomy audit showed that less than 50% of patients had a consultant surgical review within 12 hours of admission and less than 50% of applicable patients were reviewed by an older person specialist doctor following surgery. However, other performance indicators were good.
- The national bowel cancer audit showed the trust was slightly worse than the England average for most measures in the audit such as length of stay above five days (78.3 compared to 69.1%); the number of patients for whom major surgery was carried out as urgent or emergency (18% compared with 15.5%); patients seen

by specialist nurse (35.5% compared to 87.8%). However, it performed better for the number of patients for whom laparoscopic surgery was attempted (61.8% compared with 54.8%).
- Performance reported outcomes measures (PROMs) data between April 2015 to September 2015 showed the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was similar to or better than the England average.
- The standardised relative readmission risk with 28 days of discharge for some surgical patients at Oldham was higher (worse) than the England average. It was more than double for elective general surgery, higher in vascular surgery, higher for non-elective trauma and orthopaedics and higher for elective colorectal procedures. However, the risk was lower for non-elective trauma and orthopaedic procedures. We offered the trust an opportunity to provide an explanation and also describe what they were doing to combat this. They appeared to be sighted on the issue and were aware their rates here high as this had been referred to in various governance meetings and they appeared to be gathering information on why this might be; however they did not have a strategy or plan of action in place at the time of inspection.
- The division followed showed an inconsistent response to RCS standards for unscheduled care and the British Orthopaedic Association standards for Trauma (BOAST) standards. There were sometimes delays in patients receiving emergency surgery.
- Theatre utilisation was 82.5% as at September 2015; the theatre manager demonstrated the effective use of resources and effective scheduling of procedures which ensured optimum use of theatre time.

Competent staff

- New staff undertook trust inductions and completed a period of supernumerary status where their competency was assessed before they were able to work unsupervised.
- Appraisals were conducted annually with managers to review performance and feedback development issues with individual staff. Appraisals in theatres were 94% up to date, on ward T3 this was 86%, T4 was 79%, T5 was 79%, T6 was 94% and T7 was just 23%.
- Staff we spoke with said their appraisals were up to date and managers said that the current long term sickness levels have had a negative impact on their compliance figures.
- Doctors in the trust undergo their appraisals as part of their revalidation process, the trust have established a robust system for ensuring this is effective and have a 100% appraisal and revalidation record.
- The trust had procured a tailor made computer programme to assist nurses with their revalidation procedures; this assisted them with the completion and compilation of the required document. Wards had recorded the dates that revalidation was required so as to help manage the process for staff.
- Trust did not have a clinical supervision policy; therefore surgical doctors did not have formal systems for clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. Nurses though told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.
- Staff told us there were opportunities for learning and development and felt they were given the right amount of support by mentors and senior staff.
- Many staff had many years of experience in the surgical specialities and appeared competent, enthusiastic and dedicated to their work.
- Senior staff led by example and provided support and mentorship to junior staff.
- The trust had entered the new care certificate scheme for non-registered care and support staff, but only a few individuals had completed this at the time of our visit. This was seen as a positive step by most staff.
- The junior doctors we spoke with told us that the work they were doing was interesting and challenging and gave them the opportunity to develop their surgical skills and experience in a supportive environment.

Multidisciplinary working

- The surgery and anaesthesia division conducted good multidisciplinary working. Patients' care and treatment was co-ordinated between different teams and departments such as theatres and wards and the departments communicated well with each other.
- There was a good working relationship within the other hospitals in the trust; equipment, staff and resources

were shared across the various locations. If a patient's needs were better accommodated on a different site or there was theatre space elsewhere which might expedite their surgery, a patient could be transferred.
- A hybrid operating theatre had been designed and developed at the Royal Oldham Hospital; this had opened shortly before our visit. This provided a state-of-the-art environment where vascular surgery can be undertaken at the same time as interventional radiology procedures and other surgical procedures which facilitated multiple procedures being undertaken simultaneously. This demonstrated excellent multidisciplinary working and benefitted patients by preventing them having to have multiple independent procedures on separate occasions.
- Team working between the various disciplines was good and the team spirit was positive. They worked seamlessly together to provide holistic care.
- On the wards there was a joined up approach to patient care with involved ward based staff and allied health professionals such as physiotherapists, dieticians, pharmacists, social workers and specialist services such as the rapid assessment interface and discharge (RAID) mental health team.
- Pharmacists provided input into patients' individual treatment by reconciling patients prescribed medications and checking medications were available and appropriate.
- There was access to a wide range of specialist staff such as stoma care, palliative care, tissue viability specialists, which could be requested for advice and input.
- Discharge planning was undertaken with multidisciplinary input, complex discharges were coordinated by multidisciplinary team meeting and planning in conjunction with community carers and social workers.

Seven-day services

- All patients were reviewed by a surgical consultant on daily ward rounds. Every surgical inpatient was seen at the weekend on ward round, including those that may have been based on other wards.
- Pharmacy services are available between 8.30am and 5pm Monday to Friday and 8.30am – 12 noon on Saturdays and Bank Holidays. Outside these hours the service is covered by an on-call service.
- There was access to laboratories and pathology out of hours and at weekends, with test results and turnaround within an acceptable timeframe.
- There was access to diagnostic services during evenings and weekends except for MRI scans which were only available five days a week.
- There was a 24 hour, 7 days a week NCEPOD emergency operating theatre, which provided treatment for patients that required emergency surgery. If a further theatre was required theatre staff were on call to staff an additional further theatre.
- Physio and occupational therapists operated a limited service at weekends.

Access to information

- Physical notes and electronic patient records were kept up to date, were accessible and were easy to follow.
- Staff could access information and data they needed to for them to deliver care and treatment in a timely manner. They had electronic access to test results, risk assessments, medical and nursing notes.
- Computers were available with access to patient and trust information, this included access to electronic policies and protocols.
- Hard copies of minutes of meetings, relevant protocols, safety and alert information and audits were available.
- The theatre department used an electronic system to capture information about patient scheduling and theatre performance. This was capable of producing useful reports and details to enable better planning of services and improve performance.
- The patients GP received information about their procedure and treatment in the form of a written paper record, which the patient gave them. GPs also accessed patient information through the patient's online healthcare record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Whilst the majority of staff had received training and annual updates on the Mental Capacity Act 2005, we identified a misunderstanding on its application. Almost all the staff we spoke with discussed mental capacity in terms of enhanced observations and the deprivation of liberty. In this respect they applied the principles correctly and there was evidence of DOLs applications being made appropriately. However in respect of the fundamental aspects of assessing a person's capacity to

consent to treatment, particularly in cases of dementia and learning difficulties where capacity may be an issue. Staff did not formally document their actions. On occasions staff applied a 'mini-mental' assessment as part of the surgical care pathway and believed this was an assessment of a person's capacity. They did not document the actions they had taken and the process they had followed to determine whether a person had capacity or not.

- During our inspection we observed that two patients on the orthopaedic ward T7, whom staff advised us did not have capacity. Neither patients had any formal test of capacity undertaken, nor documented, explaining the justification and rationale for determining they lacked capacity. They were denied any inclusion in decisions about their care and treatment including the decision to have major surgery and the placement of a do not attempt cardio pulmonary resuscitation order on them. This is contrary to the Mental Capacity Act 2005 legislation, which states that where it is suspected that a person lacks the capacity to make decisions about their care and treatment, a two stage assessment process is conducted to ensure that this is the case, why this is and the evidence for it and that this should be documented thoroughly. A best interest meeting should then determine what the care and treatment is based on the best interests of the patient. However for both of these patients this process was not followed at all.
- When this was brought to the attention of staff on the ward including senior doctors and nurses, it was apparent that they did not understand the Mental Capacity Act legislation, nor what the correct course of action should have been indicating this was not merely an oversight but an entrenched lack of understanding.

Are surgery services caring?

Good

We rated services as good for caring because:

- Staff demonstrated a caring and compassionate attitude towards their caring of patients and their relatives.
- They communicated with patients and relatives in a sensitive and empathetic manner.
- We observed supportive and positive interactions between staff and patients
- Staff protected the privacy and dignity of their patients when providing care and treatment.
- Patients told us staff were polite and respectful and that they treated them with kindness.
- Patients stated they were kept updated and involved in decisions about their care and treatment and they had time to ask questions and have these answered to their satisfaction.
- The division achieved good friends and family test results, which were better than the England average.

Compassionate care

- The patients and carers we spoke with told us they were treated with care and compassion. They said that staff were kind and caring and treated them with dignity and respect.
- During our visit, we witnessed positive and caring interactions between staff and patients. We saw that staff introduced themselves and asked patients permission before carrying out care.
- Cubicle curtains and doors were closed during consultations and patient care and staff sought permission before entering such areas to protect the patient's privacy and dignity.
- The areas we inspected were compliant with same-sex accommodation guidelines, that is men were cared for in separate areas to females.
- The NHS friends and family test (a survey which asks patients if they would recommend the NHS service they have received to friends and family who need similar treatment or care) showed a high response rate of 36.5%. The FFT results showed from November 2014 to October 2015 97% would recommend the surgical wards at Oldham to the friends and family.
- The hospital also undertook their own inpatient survey and collated the results on a monthly basis. Feedback from those surveys showed positive results with a small minority of patients expressing dissatisfaction.
- Results from the patient-led assessments of the care environment (PLACE) showed that the trust achieved good results in 2015, we found that all the areas that had been highlighted for improvement in the report, had been addressed by the time of our visit.

- ‘Have your say… your time in hospital’ leaflets were available in pictorial and written form for people with learning disabilities to provide feedback following their hospital experience.

Understanding and involvement of patients and those close to them

- The patients and relatives we spoke with told us they found members of the surgical staff listened to what the patient and family had to say. Patients said they felt they had enough time to have their questions and concerns answered.
- Patients said they received clear information about their care in a way they understood which enabled them to make informed choices about treatment options. This is supported by what we saw during our visit where patient choice was respected.
- Patient and those close to them said they felt included in the decision making process and could contribute to planning and delivery of their care and treatment. This was reflected in the results of patient surveys.

Emotional support

- During our visit, we observed emotional support being provided by staff of all grades, who spoke with patients and relatives in a comforting and supportive way. For example, we saw a nurse providing support and reassurance to a patient who was going down to theatre for her operation.
- The trust also provided a range condition specific emotional support through the expertise of nurses specialising in cancer, colorectal and stoma, pain, cardiology, diabetes, palliative care and safeguarding.
- Assessments for anxiety and depression were carried out at pre-operative clinic or on admission. This identified those that may need greater emotional support, such as patients with phobias, mental health problems or anxiety. Any identified need which may impact on care was highlighted and where necessary a reasonable adjustments meeting was held.
- There was a patient advice and liaison service (PALS) at the Royal Oldham hospital which provided a range of advice for patients and relatives.
- Oldham offered an onsite carer and family bereavement service, which offered support for relatives of those who had passed away at the hospital. This included a counselling service together with practical help and advice. They also produced useful advice leaflets.
- The chaplaincy and spiritual service was also available for spiritual, religious or pastoral support to those of all faiths and beliefs and there was a multi-faith prayer room at the hospital.

Are surgery services responsive?

Good

We rated this service as good for responsive because:

- The hospital met the national target time of 18 weeks between referral and treatment for 95.6% of their patients.
- There was attention to individual patient needs and support for those with complex needs.
- The ward environment was adapted to meet the needs of patients living with dementia and there was implementation of many of the recommendations from dementia best practice guidance.
- Complaints were handled and responded to appropriately and the feedback was used to improve services for patients.
- Theatre utilisation was good and the division made good use of the resources and time available to them.
- There was a 24 hour emergency NCEPOD theatre.
- Bed occupancy was optimum and we saw that patients had good access to treatment.
- Patients care and treatment was appropriately planned and flowed well from admission to discharge.
- Facilities and the environment was suitable for the delivery of surgical services.
- Hospital lengths of stay for surgical patients at Oldham were similar to the England average.
- The division had lower rates of cancelled operations than the average rates across England.

Service planning and delivery to meet the needs of local people

- The surgery and anaesthesia division provided pre-planned day surgery, emergency and elective trauma and orthopaedic, urology, ENT, oral and general surgery services on site at the Royal Oldham Hospital. The local population could receive surgery in other specialities such as cardiac, neurosurgery, burns and plastic surgery through arrangements with neighbouring trusts.

Surgery

- The facilities and premises in the surgery and anaesthesia division were appropriate for the services that were planned and delivered.
- Coordinators held daily bed management meetings to review capacity and organise the availability of beds.
- There was adequate bed spaces in the operating theatre areas and the environment was organised and equipped appropriately to care for patients pre and post-operation. The division was able to determine difficulties with the flow of patients, which enabled them to respond to bottlenecks or delays.
- They had eight operating theatres, one of these was a NCEPOD emergency theatre, which was staffed 24 hours a day, seven day a week, to provide facilities for patients who required urgent surgery, this enabled access to prompt treatment out of hours and weekends.

Access and flow

- Patients were admitted through various channels including pre-planned elective and day surgery, through the accident and emergency (A&E) department or through a GP referral. Patients admitted from A&E or GP referral were transferred to the surgical assessment unit and the surgical triage unit. Some orthopaedic trauma patients went to the trauma stabilisation unit.
- NHS England stated that patients should see a specialist within 18 weeks of being referred and that trusts should aim to achieve this for at least 92% of patients. Referral to treatment times for Pennine Acute as a whole were achieved for 95.6% of patients as at 11th February 2016 and this included medical treatment. However individual surgical specialities compliance at 31 December 2015 was 94.7% for general surgery, 95.7% for urology, 97.1% for ophthalmology, 94.8 for trauma and orthopaedics, 96.5% for oral surgery, 95.0% for ear, nose and throat surgery, 99.0% for plastic surgery and 97.9% for cardiothoracic surgery.
- Bed occupancy rates for surgical wards on average was 89% from August 2015 to January 2016. This is similar to average figures from comparable trusts and the England average of 89%. However on individual wards this ranged from 98% on T4 (surgical triage and elective general surgery), to 70.5% on T6 (general surgical admissions unit).
- Between July 2014 and June 2015 hospital episode data (HES) showed the average length of stay for elective surgery overall at the hospital was 3.5 days, which was marginally higher (worse) than the England average at 3.3 days. For elective colorectal surgery, the average length of stay is 6.8 days, which was higher (worse) than the England average at 6.0 days. However for elective vascular surgery length of stay was 3.2 days which is shorter (better) that the England average of 4.5 days and for elective trauma and orthopaedic surgery length of stay was 2.3 days which is shorter (better) that the England average of 3.4 days.
- For the same period the average length of stay for non-elective surgery 5.3 days, which was higher (worse) than the England average at 5.2 days. For non-elective trauma and orthopaedic surgery length of stay was 6.0 days, which was lower (better) that the England average of 8.7 days; vascular surgery length of stay was 9.9 days, which was lower (better) that the England average of 12.0 days. However, for general surgery the average length of stay is 4.3 days, which was slightly higher (worse) than the England average at 4.2 days.
- From August 2015 to January 2016 11,025 operations were scheduled. Of those 203 or 1.8% were cancelled for all reasons. Of those, 91 had been cancelled for non-clinical reasons, which equated to 0.8% of all operations. Cancellation for clinical reasons may be the patient is ill or has not fasted properly; cancellation for non-clinical reasons includes no available beds, lack of staff, lack of equipment, running out of time etc. These figures are much lower (better) than the average across England figures.
- Trust wide from January 2015 to December 2015 895 were cancelled for non-clinical reasons, of those 10 were not treated within 28 days. This was much better than the average rate across England. This information could not be desegregated to individual hospitals.
- Staff planned for patients' discharge by liaising with community healthcare teams, social services, care providers, district nurses and others in order to facilitate a patient's return to the community.
- Discharge letters included all relevant clinical information relating to the patient's stay at the hospital which were given to the patient and a copy sent to their GP.
- Patients who were cared for outside of their speciality ward are known as outliers. It was sometimes the case that medical patients were cared for on surgical wards. Staff looking after such patients were competent and capable of doing so and such patients were reviewed by their consultant as part of their ward round and were repatriated as soon as a bed became available.

- We attended one of the hospital's bed management meetings which were held regularly throughout the day to review and plan patient capacity. We saw that staff were able to review and respond to acute bed availability pressures.

Meeting people's individual needs

- The surgery and anaesthesia division operated good system for identifying patients with complex needs particularly those that entered the service through the pre-operative assessment unit. We saw evidence that needs were highlighted and there was forward planning for those with living with dementia, learning difficulties and mental health problems.
- The trust operate a learning disability service which is part of the safeguarding team, they provide help and advice and a point of contact for surgical patients, carers and staff around the care and treatment of patients with a learning disability on admission, as an inpatient and upon discharge. They ensure that reasonable adjustments have been considered and implemented effectively.
- The trust used a leaf symbol to indicate that a patient was frail and a butterfly symbol to indicate that a patient was at the end of life. These discreet symbols alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments.
- Patients over 65 were screened for dementia upon admission, this involved the completion of a 'mini-mental' and followed CQIN guidance.
- The hospital had implemented the 'forget-me-not' scheme into their care of patients living with dementia. This was a discrete flower symbol, which served a reminder to staff that patients might need reasonable adjustments or a different approach to care giving. This was to ensure that patients received the appropriate level of care, to reduce the stress for the patient and to maintain their safety.
- There was a dementia nurse consultant who was clinical lead for dementia who provided support for staff and a central point for queries. The trust also had access to a psychiatric liaison team who saw and assessed appropriate patients with a cognitive impairment.
- The environment was designed to support the needs of patients living with dementia. All the wards we visited and had dementia friendly signage and images on bays and bedrooms. They also had a clock with today's day and date displayed. They followed recommendations in terms of door surrounds, paintwork and flooring. Toilet and shower areas were clearly signed, at the appropriate height and using pictorial images as well as written word. Toilet seats were in a contrasting colour to the walls and floor of the bathroom areas all in keeping with best practice recommendations. Memory boxes were available for staff to share with patients and knitted 'twiddle muffs' were available so patients had something to occupy their hands. Twiddle muffs have been found to provide a source of visual, tactile and sensory stimulation for people living with dementia.
- If a patient was identified to have individual needs, they were allocated a side room were where possible, but this was not always possible due to the configuration of wards in the older buildings. Relatives and caregivers were allowed to stay with the patient if required.
- The division had a dementia strategy covering 2015 to 2018, this included key objectives such as early diagnosis and improved quality of care and it outlined how the objectives would be met and how success or otherwise would be measured.
- The Trust had access to a range of languages through an interpreting and translating service and had their own full time interpreters for local commonly spoken languages. They could also arrange lip reading and sign language services for those who required them.
- The surgery and anaesthesia division produced a wealth of leaflets and condition or procedure specific information. These were printed in English, but on the reverse there was information on how to obtain these in other languages, written in those languages and script. They were also available in large and easy to read text.

Learning from complaints and concerns

- Patients knew how to complain and raise concerns, there were posters and information on noticeboards and complaints leaflets were available around the hospital which provided information on how to complain.
- The leaflet was clear and simple; it provided information on different ways to complain including email and telephone, it also gave advice on the Patient Advice and Liaison Service (PALS), advocacy services and the parliamentary ombudsman.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.

Surgery

- The trust recorded complaints electronically on the trust-wide system. These were allocated to the local managers and matrons who were responsible for investigating complaints in their own areas. Local managers tried where possible to seek local resolutions of concerns rather than going through the complaints process. Where formal complaints were received, the trust set a target to respond to these within 60 days.
- The surgery and anaesthesia division at Royal Oldham hospital received 25 complaints between December 2014 and December 2015, the majority of those related to patients' clinical treatment.
- Complaints were discussed at divisional governance meetings and complaints groups and learning was circulated by Monday message, team meetings, safety huddles, emails and newsletters.
- During our visit, we saw evidence that wards acted on information learnt from complaints and took action to make changes to improve patients' experience.

Are surgery services well-led?

Good

We rated this service as good for well-led because:

- Managers were competent and enthusiastic about their service and there appeared to be a positive supportive culture throughout the wards and departments. Staff felt supported and there was good team working at all levels.
- Staff were fully aware of the strategy and direction of trust and their role in that vision; they saw positive changes in the last 12 months and were optimistic about the future.
- The division engaged with staff through listening in action initiatives and feedback mechanisms. They introduced initiatives to empower staff to make improvements in their working environments which improved staff inclusion and morale.
- The division engaged with the public through matron walk arounds, listening events and feedback cards, to gain an undertsnading of patients' experience. They paid attention and made positive changes to services based on this information.

Vision and strategy for this service

- The trust vision was to be "a leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.' Their mission statement was "to provide the very best care, for each patient, on every occasion". Their values were 'Quality Driven, Responsible, Compassionate'.
- The Trust had overarching strategic goals working through until 2020 and had produced a 'trust transformation map', which illustrated the plan. This was displayed around the hospital and was readily recognised and understood by staff in the division.
- Their immediate plans for 2015/2016 were 10 corporate priorities they described as 'raising the bar', these were the most important fundamental standards the sought to improve. These had also been depicted on posters around the hospital and formed the focus of improvements on wards and department by local managers.
- Staff had a clear understanding of this vision and strategy, what they were working towards and what this meant for them personally.

Governance, risk management and quality measurement

- We reviewed the risk register for the surgery and anaesthesia division and found that risks were documented and escalated appropriately with action plans in place to address the issues identified. The risk register was reviewed and updated at clinical governance meetings.
- A clinical governance system was in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. Regular governance meetings took place to review issues of note. However, we note that some issues of concern such as delays in surgery for trauma and orthopaedic patients had been raised several times at quality and governance meetings over the past year, yet still no actions plans or resolutions had been implemented to improve the service provided to such patients.
- The division take part in various local and national audits and use the results to make improvements to services.

- Team meetings and safety huddles were held regularly to discuss day-to-day issues and to share and learning from complaints, incidents and audit outcomes. Key information was also shared on notice boards, in staff rooms and by email and newsletters.
- Individual ward managers audited aspects of care and treatment, such as compliance with risk assessment documentation, completion and review of care plans, comprehensive and legible documentation, medicines management and discharge planning. Any issues were raised at staff meetings and safety huddles in order to raise standards.

Leadership of service

- There were clearly defined leadership roles across the surgery and anaesthesia division. Leadership of each clinical group was through a triumvirate arrangement, which was relatively new to the trust and division.
- Staff stated that they knew who the executive team and board members were and that they were visible and responsive.
- Individual ward managers appeared enthusiastic, competent and hardworking and were well thought of amongst ward staff. Nursing staff told us they felt supported and that there were good working relationships within the teams.
- Trainee and junior surgeons told us that senior staff were accessible and supportive and they received good leadership and direction.

Culture within the service

- Staff appeared to be happy working with the Oldham surgery and anaesthesia division, whilst they told us it was very busy, they were happy in their work. They said that they were well supported within their teams and spoke very highly of their individual ward managers.
- Staff we spoke with said they felt able to speak up if they had concerns or had made a mistake, they said there was a no blame culture in place.
- The staff survey results from 2015 show the Trust performed in the bottom (worse) 20% of all Trusts; however staff said that morale had improved greatly over the last 12 months and that they could see positive changes in their day to day work. They felt optimistic for the future and felt that things would continue to improve.

Public engagement

- Surgical matrons undertook listening clinics where they visited wards and spoke with patients, relatives and visitors and gained feedback on the services provided. The feedback was used to make positive changes in the environment and practices and we saw examples of this during our visit.
- The division undertook patient surveys to obtain feedback on their service; they used this information to make improvements in quality and service. They used this information to make changes to the layout of the orthopaedic block.
- Information on how the public could provide feedback was displayed in the surgical wards and corridors and information on how to engage with the division and the trust were provided on their internet site.
- Trust information, policies and operational plans including those relating to surgery and procedures were available on the trust website.
- The trust engaged with the public through social media sources and their sites were up to date and current. This system provided information about all services but included information and advice specific to surgery and surgical wards, this was found to be particularly useful in updating patients what to expect regarding their appointments and surgery during episodes of industrial action.
- The trust operated a membership scheme and had 21,000 members. The members had the opportunity to provide input into trust decisions, take part in surveys, elect governors and received a member's newsletter.

Staff engagement

- Staff received regular communication from the trust and the surgery and anaesthesia division. Communication was circulated to staff regarding wider trust and hospital information together with more specific information relating to incidents, complaints, safety and local changes. Communication took the form of meetings with line managers, team meetings and safety huddles.
- Both the wider trust and the division engaged with staff using electronic means, emails, newsletters and through posters displayed on notice boards in staff areas.
- Staff could access information electronically on the trust intranet; there was easy access to policies and procedures, daily safety alerts and updates in practices.
- Staff participated in a feedback process called 'listening in action' in which staff gave feedback to the trust executive board on their concerns, their ideas and what

they wanted to change. Staff told us this had a positive impact on their experience and job satisfaction as they felt they could contribute and their contribution was valued.

- Staff from the division were invited to be involved in annual staff surveys to feedback their experience of working at the Trust. Although the feedback was not division specific, staff viewed the process favourably and believed it had led to improvements in the last year.
- Staff from the surgery and anaesthesia division were consulted for their ideas and experience in the 'well organised ward' assessments. They took ownership of projects which not only improved the running of the surgical wards but improved teamwork and inclusion of all team members.
- The trust held events to celebrate the achievements of staff such as an annual awards ceremony, employee of the month nominations and awards and certificates of achievement. The staff from the surgery and anaesthesia division cited this as a positive initiative which motivated improvement and increased a sense of trust identity.
- Pennine Acute NHS Trust provided a free counselling service for employees to help with issues such as work related problems and personal life problems; they also offer a free course of cognitive behavioural therapy treatment.
- The trust had recruited the services of an external performance monitoring and contact company which managed the sickness and absence processes. They handled calls from staff calling in sick, provided wellbeing and welfare advice. Staff in the surgery and anaesthesia division felt this was a positive change and felt more supported through their sickness.

Innovation, improvement and sustainability

- A hybrid operating theatre opened at the Royal Oldham Hospital, which was a brand new state-of-the-art environment where vascular surgery could be undertaken at the same time as interventional radiology and other surgical procedures. This encouraged interdisciplinary and multidisciplinary working and reduced the risk to patients by enabling them to undergo simultaneous imaging and surgical procedures rather than undergoing multiple procedures and anaesthesia.
- The trust has shown commitment to environmental sustainability by reducing its carbon footprint and looking at ways to better use consumables and resources. The surgery and anaesthesia were part of this initiative to make better use of resources.
- The trust and division were working towards financial sustainability by reorganising care delivery and service provision and improving efficiency.

Critical care

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

Information about the service

The Royal Oldham Hospital (ROH) provides critical care services in an eight bedded level 3 facility (ITU) and an eight bedded level 2 facility (HDU). The units are physically next door to each other but from a medical leadership perspective are run quite separately. The ITU being run by intensivist/anaesthetists and the HDU effectively having no designated medical leadership with referrals being made from any of the hospital's surgical and medical teams. There is joint nursing leadership of the two units.

Both areas have side rooms for the purpose of isolating patients that present an increased infection control risk. A limited critical care outreach service is also provided.

According to the most recently validated and published intensive care national audit and research centre (ICNARC) data for January 1st to 30 September 2015, the ITU had 281 admissions and the HDU had 539. The service is a member of the Greater Manchester Critical Care Network (GMCCN). For the purposes of governance, critical care sits in the trust's division of anaesthesia and surgery.

As part of the inspection we visited the units on 24 February 2016. We spoke with senior and junior medical staff, 11 members of the nursing team, three members of support staff, two patients and one set of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

When considering the performance of the critical care service at The Royal Oldham Hospital it should be noted that the judgements reflect the aggregated findings of both the level 3 (ITU) facility and the adjoining level 2 (HDU) service.

It should also be noted that the "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care and the Guidelines for the Provision of Intensive Care Services (GPICS) Standards.(2015) apply equally to both level 2 and level 3 services. Critical care incorporates both intensive and high dependency care.

We rated critical care services as inadequate because:

- We determined that the care on the HDU was putting patients at risk of harm. There was no designated clinical medical lead for the level 2 HDU unit. As a consequence of this lack of leadership there were significant shortfalls where the national service specification for critical care (D16) and the GPICS standards were not being met on that unit.This is in breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The nurse staffing on both the ITU and HDU failed to meet the standard set by the Intensive Care Society

Critical care

for supernumerary shift co-ordinators at band 6/7. This is in breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a critical care outreach team but this did not cover all of the wards and was not delivered 24/7.
- The hospital was non-compliant with a number of elements of the NICE clinical guidance around the rehabilitation of critically ill patients.
- There was a problem with delayed (both units) and out of hours discharges (HDU). The ICNARC data for July to September 2015 showed that 23% of the discharges from HDU occurred out of hours.
- It was not clear how risks to critical care were being managed. The risk register reported risks that had been identified for a number of years but there was a lack of clarity about mitigating actions, progress and review.

However:

- The units both contributed data to the intensive care national audit and research database (ICNARC). The most recent data showed that mortality rates for both level 2 and 3 areas was in accordance with comparable units.
- Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect.

Are critical care services safe?

Inadequate

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- The nurse staffing on both the ITU and HDU failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7. This is in breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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Are critical care services safe?

Inadequate

We rated critical care services as inadequate for safe because:

- Our concerns related to the level 2 (HDU) area. There were eight beds into which level 2 (HDU) patients were admitted at the ROH. The medical care to these patients was provided by medical staff (Consultants, trainees and/or speciality doctors) from the patients' parent teams. About 75% of these patients were generated from medicine with the balance largely from surgical specialities. The parent team refers to the speciality and consultant under whom the patient was admitted to hospital, e.g. medicine or surgery. Consequently the unit was failing to meet several of the key service outcomes for critical care patients as set out in the "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care and the Guidelines for the Provision of Intensive Care Services (GPICS) Standards (2015). It should be noted that the GPICS standards apply to both level 2 and level 3 services.
- For example, there must be a designated Clinical Director and/or Lead consultant for Intensive Care. The HDU did not comply with this standard. Once admitted to Critical Care, care must be led by a Consultant in Intensive Care Medicine. The HDU did not comply with this standard. Consultant intensivist led multi-disciplinary clinical ward rounds within Intensive Care must occur every day (including weekends and national holidays). The ward round must have daily input from nursing, microbiology, pharmacy and physiotherapy. The HDU did not comply with this standard.
- All admissions to critical care must be seen and reviewed within 12 hours by a consultant in intensive care medicine. In the level 2 (HDU) area this was not happening. A local audit had shown that only 50% of patients on the HDU were seen within12 hours their parent team. Patients on the HDU were often not getting a timely review by a senior decision maker. The level 3 (ITU) area was led by a designated intensivist so referrals were from consultant to consultant with the intensivists determining who would be admiited into the critical care level 3 beds and who would be discharged.
- The most recent review by the Greater Manchester Critical Care Network in May 2015 identified some serious concerns. Most notably around the HDU patient pathway and the lack of timely review by an intensive care consultant. By the time of this inspection this situation had not improved and as a consequence patients were at risk of receiving sub-optimal care.
- Neither of the two units were meeting the standard for there to be a supernumerary clinical shift co-ordinator at band 6/7, 24 hours a day. It was noted that the nursing budget for critical care across the trust was tasked with a cost improvement plan of £140,000.

Incidents

- The trust had a policy and electronic system for the reporting and management of incidents and related investigations.
- Staff were familiar with the reporting system and were able to give examples of when they had used it.
- We saw a report extracted from the incident reporting system, which showed all incidents reported for the critical care areas within the trust for the period 01/12/2014 to 30/11/2015. The report showed that at the Royal Oldham Hospital there had been 79 incidents reported for the ITU. Of these reported incidents there had been two near misses for medication errors, 16 were reported as causing a moderate impact (eight of these were pressure ulcers) and 16 were reported as having a low impact upon the patient (again, 10 of these low impact incidents related to the development of hospital

acquired pressure ulcers). The remainder of reported incidents were rated as causing no harm. Of these remaining 45 'no harm' incidents there were ten relating to out of hours transfer of patients to the ward.

- For the same time period there had been140 incidents reported from the HDU. Of these reported incidents, there had been two near misses relating to equipment failure, two were rated as having a severe impact on the patients, three caused moderate harm, 17 were reported as having a low impact on the patients and the remaining 116 were reported as causing 'no harm'. Eighty two of the no harm incidents related to patients being moved out of hours, i.e. after 22.00 and before 07.00.
- According to the aforementioned report for the ROH site there had been only one incident raised as a consequence of the delay or unavailability of a doctor. This does not correlate with the information from staff that there was a consistent problem trying to get medical staff to review HDU patients. When we asked staff about this, they said that the issue of requesting doctors had become so commonplace that it was no longer raised as an incident.
- Incidents were reported and discussed at the monthly critical care directorate meeting.
- Staff told us that incidents and learning was also shared during the daily safety 'huddles' on the unit.
- Monthly mortality and morbidity meetings took place in respect of the ROH. Though from the records shared with us it was not clear who attended, what learning was being taken and diseminated. The minutes were also short in detailing what the resulting actions were or who was responsible for taking them forward.
- Staff had varying levels of understanding about duty of candour. The trust had introduced training on duty of candour for senior nurses and managers within the trust but the detail and principles had yet to be embedded for all staff. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

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

Cleanliness, infection control and hygiene

- Clinical areas, offices, corridors, store rooms and staff areas were visibly clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- During the inspection we observed staff appropriately washing their hands, using anti-septic hand gels and wearing personal protective equipment when delivering clinical and personal care.
- An infection control audit of the HDU in April 2015 recorded an overall compliance level of 91% with the audit tools used (85% or above indicated compliance). The audit, carried out by the trust's infection control team, identified shortfalls in compliance in the ward kitchen, the ward environment and the handing of sharps.We saw no evidence of steps taken as a result of the audit.
- The most recently supplied ICNARC data for the HDU (July to September 2015) showed no cases of unit acquired infections with Methicillin resistant staphylococcus aureus (MRSA) and small numbers of unit acquired Clostridium difficile (C diff). Infection rates were generally better than comparable units.
- For the same period on the ITU at Royal Oldham, in terms of unit acquired infections in blood for ventilated admissions, performance was comparable with similar units. For elective surgical admissions there were no cases of unit acquired infections in blood. For emergency surgical admissions the last reported case of a unit acquired infection in blood was in quarter one of 2014. Unit acquired MRSA and C diff infection rates were better than comparable units and no cases of MRSA bacteraemia had been reported.

Environment and equipment

- As highlighted in the Greater Manchester Critical Care Network review in May 2015, neither the HDU or the ITU complied with the most recent health building note guidance (HBN 04-02).
- The HDU area physically had the capability of housing 10 beds although was staffed for eight beds, including

two side rooms. There was an issue around confidentiality in the HDU. When staff were at the nurse's station, talking or on the phone, their conversations could be overheard by patients and visitors.

- There was an inventory of all equipment. The electro bio-medical engineering (EBME) department was conducting an audit to try and establish the whereabouts of all equipment as some was missing. We saw the inventory, which included the date of the last service and the next planned maintenance. However, the schedule showed numerous items of equipment that had gone beyond the date at which they were due for service.
- There was a large area within the HDU footprint that was used as a joint equipment store for the two units. Numerous pieces of equipment were stored and charged there. We looked at many of the items of equipment to ascertain when they had last been serviced. All the equipment we looked at had a date sticker indicating the date of its last service but it was not clear from this when the next service was due.
- We checked two bed spaces on the HDU and they were clean and free from any dust. We also checked the sluice areas, which were also clean and tidy, including the commodes.
- Clinical stores were well labelled, stored neatly and were off the floor.
- We saw that resuscitation equipment; including defibrillators and difficult airway management trolleys were available. Records indicated that these were all checked daily against a contents list, then signed and dated.

Medicines

- The unit used an electronic prescribing system (EPMA), which could be accessed at the bedside.
- The drug room on the HDU was positioned and designed that if two nurses were checking drugs therein, it was not possible to hear any noise coming from the adjoining bed areas. This included monitors and alarms.
- We were told by staff that on occasions when it had proved difficult to get a doctor to attend the HDU to review a patient then medicines had been prescribed remotely using the EPMA system. On these occasions it meant that the doctor did not personally see the patient in question at the time that they prescribed the medication.
- With various parent teams managing the care of patients on the HDU, there were at times inconsistencies in practice. For example, nurses did not have standard protocols in place for the management of potent vasopressor infusions.
- The Greater Manchester Critical Care Network (GMCCN) review of May 2015 noted variation on medicines management practices across the trust. For example, drug concentrations and the use of potassium.
- Controlled drugs were stored in separate locked cupboards with the keys being held on the person of the nurse in charge of the shift. Controlled drugs were subject to a daily check.
- The units at ROH were not compliant with the GMCCN standard for dedicated pharmacist cover. The standard states that all critical care units should have a critical care pharmacist.
- There were nine medicines related incidents raised on the electronic system from the ITU and HDU at Royal Oldham Hospital between 01/12/2014 and 30/11/2015.
- Unregistered healthcare practitioners were able to administer a restricted range of medicines once they had demonstrated the appropriate competencies and received the required training. For example, a 10 ml sodium chloride 0.9% flush after a cannula insertion.

Records

- We looked closely at two sets of patient records in the level 2 or HDU area. The medical/nursing records were paper based and comprised a range of clinical records, assessments and plans. These included for example, VTE risk, delirium, nutritional risk, falls assessments, physiotherapy treatment plans and skin care bundles. One file was used for multi-disciplinary entries. All entries were completed, signed and dated.
- Although entries in records were signed and dated and in most cases included the author's professional registration number. For example, General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration numbers.
- In the two sets of notes we examined on the HDU there were documented delays in patients being reviewed by their parent teams. In one set, there had been no consultant review recorded for two days.
- Physiological parameters were recorded by the nurse looking after the patient on paper charts located close to the bedside. The charts that we looked at were

comprehensively and accurately completed and brought together in one place all the patient's physiological monitoring, blood results, care planning and management.
- The unit was using electronic prescribing, which was accessed via a bedside laptop.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding training formed part of the trust's mandatory training programme. According to the figures supplied 97% of the registered nurses on the ITU had completed level 2 safeguarding training for both adults and children. Disaggregated figures were not available for the HDU.
- The trust had named nurse leads for safeguarding adults and children.

Mandatory training

- The practice based educator had oversight of the nurses mandatory training. There were records kept of the trust mandatory training, which included fire prevention, infection prevention and control, moving and handling, hand washing, information governance, equality and human rights, safeguarding adults and children (level 2), risk management, health and safety and waste management. The records indicated the frequency of each subject. For example, information governance training was required annually whilst safeguarding training was undertaken every three years.
- The most up to date mandatory training records seen for the critical care units at ROH were from November 2015. They showed that the overall mandatory training compliance rate was 95% and 100% for the outreach team.
- Additional training required for critical care staff was delivered on training days set up on the unit. For example, dementia training, mental capacity, blood transfusion, fire lecture, delirium update and administration of intra-venous opiates.

Assessing and responding to patient risk

- A range of patient risk assessments were undertaken on admission and repeated on and on-going basis as required. These included for example, nutritional risks and the risks of developing pressure ulcers.
- The wider hospital used an early warning score system (EWS). EWS systems were introduced with the aim of providing a simple scoring system, which could be readily applied by both nurses and doctors to help identify early and quickly deteriorating patients. The EWS uses an aggregated weighting system with physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation.
- Training in the use of EWS for ward staff was facilitated by the hospital's critical care outreach team (CCO). The CCO comprised four band 7 practitioners plus an additional 15 hours of band 7 per week. This enabled an outreach service at ROH from 07.45 to 20.15 Monday to Friday and 07.45 to 14.00 at the weekends. So outreach was not provided 24/7.
- The function of the outreach team was to identify patients at risk of deterioration by championing the EWS and trust escalation policy, to provide monitoring and support for patients discharged from critical care and so prevent any readmissions, teaching ward staff and assisting with the management of patients deteriorating who required admission for level 2 or 3 care and treatment. The outreach service did not cover all the ward areas at ROH. There was a face to face handover from the outreach team to the night nurse practitioner team. Patients who were causing concern in respect of their EWS or who had just been stepped down from critical care were then discussed.
- There were examples of patients admitted to the level 2 or HDU as a consequence of a lack of pre-operative elective screening. For example, a patient with sleep apnoea required admission over night after surgery. Had the patient gone through elective screening then this condition should have been identified and planned for. The "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care states that the provider should ensure appropriate planning of elective surgical admissions to critical care in order to avoid unnecessary postponement of surgery.

Nursing staffing

- On the day of inspection both the ITU and HDU were safely staffed in terms of the numbers of bedside nurses on duty. Based on the intensive care society acuity

standard there should be one nurse for every level 3 patient and one nurse for every two level 2 patients, to deliver direct care. These are the expected staffing levels irrespective of the shift, both day and night.
- Nurses were supported to deliver care and treatment by both clinical and non-clinical support workers.
- The units also had a designated lead nurse who had responsibility for the nursing elements of the critical care service
- However, neither unit met the standard for supernumerary cover. The intensive care society standard states that there will be a supernumerary clinical co-ordinator at band 6/7 on duty 24/7. Neither unit had a clinical co-ordinator on duty. The nurse in charge of the each unit was working clinically to care for patients. This issue was well known to the trust and was highlighted as a concern in the May 2015 review by the GMCCN.
- Despite the units not meeting the standard for nursing cover, they were often asked to supply staff to assist the other critical care areas within the trust.
- Along with the other critical care units in the trust, the nursing budget was subject to a £140,000 cost improvement plan for the coming year.
- No agency nurses were used. Any extra shifts were carried out by the unit's own staff that were duly paid an overtime rate.
- Shift to shift and bedside handovers were undertaken morning and evening.
- We carried out an unannounced inspection to the level 2 HDU on Thursday 17th March. There were eight level 2 patients on the unit at the time. The nurse staffing comprised four trained nurses and one healthcare assistant. There was no supernumerary shift co-ordinator.

Medical staffing

- In terms medical staffing and leadership the ITU and HDU were run quite differently. The ITU was a closed unit, clinically led by intensivist/anaesthetists who were able to gate keep the admissions and discharges. With input from the parent teams as appropriate the clinical care was directed and delivered by the intensivist/ anaesthetists. However, the HDU was not led by the intensivist/anaesthetists. It was not clinically led by any designated consultant. It was an open unit with potential referral and admissions from any speciality within the hospital.
- Consequently this meant that on the HDU many of the standards for critical care as set out in the "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care and the Guidelines for the Provision of Intensive Care Services (GPICS) Standards.(2015) were not being met. For example;
- There must be a designated clinical director and/or a lead consultant for critical care. This was not the case in the HDU.
- Once admitted to critical care, the care of the patient must be led by a consultant in intensive care medicine. This was not the case in HDU.
- A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and undertake twice daily ward rounds. This was not the case in HDU.
- Level 2 critical care patients were not seen by a consultant in critical care medicine within 12 hours of their admission. The patients on HDU were managed by their respective parent teams who also had responsibilities within the rest of the hospital, e.g. clinics, theatres. So patients on the HDU, although they were level 2 patients, were not always given the highest priority by their parent team.
- On the ITU, clinical consultant led ward rounds took place twice a day Monday to Friday and once at weekends. A structured consultant to consultant shift handover took place. The ITU also had support 24/7 from a staff grade doctor.
- On the HDU, patients were not always reviewed by a senior doctor in a timely way. There was no set time for ward rounds.
- Out of hours cover also varied between the ITU and HDU. For the ITU there was always a consultant on call. The HDU relied upon the on call doctors from the respective parent teams.
- We carried out an unannounced inspection to the level 2 HDU on Thursday 17th March at 18.15. There were no doctors based on the unit at the time of our visit. Staff told us that since the announced inspection, there had been a consultant, sourced from ITU or the anaesthetic rota, on the HDU from 8am to 1pm, seven days a week. We were also told that from Monday March 14th consultants were expected to cover the HDU from 8am to 6pm and this had happended from Monday 14th

March to Wednesday 16th March. Although on the 17th March the cover had reverted to 8am to 1pm. This cover meant that the consultant did a daily ward round with the nursing staff on HDU.

Major incident awareness and training

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

Are critical care services effective?

Requires improvement

We rated this service as requires improvement for effective because:

- The hospital was non-compliant with a number of elements of the NICE clinical guidance around the rehabilitation of critically ill patients.
- The critical care outreach service was not provided 24/7 and with the level 3 ITU being a closed unit and not amalgamated with the level 2 HDU, true multi-disciplinary working was not being achieved.

Evidence-based care and treatment

- The unit supplied continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the Greater Manchester Critical Care Network (GMCCN). The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- Following the most recent GMCCN review in May 2015 there were a number of serious concerns identified as follows;
  - The review demonstrated serious concerns about the patient pathway at the level 2 unit at Royal Oldham hospital. It was not always clear to clinical staff on the unit who the patient's consultant team were. This was particularly true at out of hours and weekends. It is essential to ensure patient safety that the named consultant is known at all times.
  - Patients in the HDU at ROH were not being seen and reviewed by the parent consultant. It is a standard for patients in critical care to have as a minimum a daily consultant review.
- There was a range of local policies, procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust wide intranet.
- Trust wide there was noncompliance with aspects of NICE guidance 83 'Rehabilitation after critical illness'. The trust had carried out a gap analysis to identify the areas of non-compliance though this wasn't disaggregated for the individual hospital sites.
- We saw a trust wide critical care audit plan, though it was not clear if all the audits had yet taken place.
- We did see evidence of a range of local audit activity for ROH, which included assessments of compliance with care bundles relating to ventilator acquired pneumonia (VAP), a network audit of compliance with skin bundles and audits on antibiotic prescribing for both the HDU and ITU at the Royal Oldham Hospital.
- The skin bundle audit, September 2015, showed good levels of skin bundle compliance for both admission and on-going care actions though again the data was not disaggregated so it was not possible to determine separately the ITU and HDU performance.
- The findings of the antibiotic prescribing audits showed compliance with trust policies.

Pain relief

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

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately in the patient's notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.

Critical care

Patient outcomes

- Both critical care units at ROH contributed data to the national database for intensive care (ICNARC), which enabled their respective performance and outcomes for patients to be benchmarked against similar units nationally.
- The most recent ICNARC data supplied for the units was for the July to September 2015 quarter. The data for the HDU showed that from July to September 2015 there had been 181 admissions, 55% were male and the average age was 62 years. Eleven percent of the admissions were elective or scheduled and 75% of admissions were non-surgical in speciality. In terms of early readmissions the unit was performing generally better than comparable units. For mortality, there had been 28 observed deaths against the expected 24.3 using the ICNARC (HDU) model giving a mortality ratio of 1.15. This was within the expected limits for comparable units.
- The data for the ITU for the same period showed there had been 91 admissions, 63% were male and the average age was 59 years. Only 8% were elective or scheduled admissions and 71% were non-surgical. For the last two quarters mortality for ventilated admissions was slightly worse than in comparable units though the numbers of unit acquired infections in blood was better than comparable units. For admissions with severe sepsis and/or pneumonia mortality was no different than in comparable units. For admissions with trauma, perforation or rupture the mortality rate was higher than for comparable units. Using the ICNARC (2013) model the mortality ratio was 1.35 with 26 observed deaths against an expectation of 19.3. This was within the expected limits for comparable units.

Competent staff

- Nursing staff were appropriately trained, competent and familiar with the use of critical care equipment.
- There was a full time practice based educator working across both critical care units. As with the other practice based educators in the trust, there were four in total, they were unit based. Funded by the critical care network they also worked part of their time with the Skills Institute. They were responsible for new starters for the first twelve months of their employment and worked alongside new staff to support them through the Step one critical care competencies. Once the Step one competencies had been completed then nurses were eligible to apply for the critical care course run in conjunction with Manchester Metropolitan University. At the time of inspection 92% of the trained nurses in the critical care units at ROH had completed the critical care course.
- All nursing staff had to undertake an assessment package before they were judged as competent to administer intra-venous opioids by bolus injection.
- The practice based educators were also responsible for completing the first personal development review (PDR) for new staff.
- Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good opportunities for training.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- All staff were subject to an annual appraisal. According to the data supplied by the trust the latest available figures showed that 91% of registered nurses in critical care at ROH had received an appraisal in 2014/15. There was no data provided for the current year.
- The health care assistants were also able to develop by undertaking modules in physiological observations such as blood pressure, temperature and pulse. They also had an opportunity to complete the acute illness management course (AIM).

Multidisciplinary working

- The nursing staff on the critical care units at Royal Oldham Hospital rotated between the ITU and HDU. The allocation to HDU was usually for a period of three months.
- We also saw that nursing staff did move from ROH critical care units to cover shortfalls both within other trust critical care units and internally within ROH. This, despite the fact that none of the units met the Intensive Care Society standard for a supernumerary clinical shift co-ordinator.
- The medical staff working on the ITU did not usually become involved with the care of any patients in the HDU. We did hear anecdotal evidence to suggest that on occasions, the ITU doctors had responded to requests for assistance from HDU nurses but this was ad hoc and inconsistent and appeared to depend upon individual professional relationships.
- The recognition of and management of the deteriorating patient at ward level sits within the

national critical care specification (D16). There is a requirement to undertake as a minimum an annual audit on the quality of clinical observations and effectiveness of the track & trigger system being used. The outreach team at ROH looked at their activity for the period 01/01/2015 to 30/11/2015 and produced the following analysis;

- Total of 1171 patients seen.
- 462 patients followed up from HDU.
- 114 patients followed up from ITU.
- 376 patients triggered on early warning system (EWS).
- 129 with acute kidney injury.
- 11 cardiac arrests.
- 67 patients causing concern and seen though not triggering on EWS.
- 14 requiring specialist help.
- 1 patient with a laryngectomy.
- 6 patients with tracheostomy.

- Consultant led multi-disciplinary ward rounds took place each day on the ITU. Although some members of the multi-disciplinary teams attended at a different point during the day and all members did not always attend at the same time.
- We saw good multi-disciplinary working between nurses and allied health professionals on both units.
- Level 2 critical care patients on the HDU had to wait for review by their parent teams and this did not always include a consultant review. There were no multi-disciplinary ward rounds undertaken on the HDU. Nursing and ward clerk staff spent considerable amounts of time chasing up doctors to review their patients. Staff reported that it was a daily challenge to secure a timely review for level 2 patients. This reduced the time available to deliver bedside care to patients.

Seven-day services

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

Access to information

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

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

- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care.
- We did not see any deprivation of liberty applications for patients in the critical care unit.
- There was an assessment of mental capacity/delirium recorded in the patient record. This was called the 'CAM-ICU' and was used in conjunction with the Richmond Agitation Scale, which measured the agitation or sedation level of a patient.
- The trust had developed a delirium prevention care bundle, which had been adopted by the GMCCN. Although its understanding and application had yet to be thoroughly embedded into practice.

Are critical care services caring?

Good

We rated this service as good for caring because:

Critical care

- Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect.
- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- The nursing team on the level 2 high dependency unit continued to care for their patients in a supportive and compassionate manner. This, despite their obvious frustrations at the way in which the lack of medical leadership on the unit often left them struggling to deliver the level of care that they aspired to.

Compassionate care

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

Understanding and involvement of patients and those close to them

- We saw that staff communicated with people so that where possible they understood their care and treatment. This was corroborated by a patient that we were able to speak with during the inspection.
- We spoke with one patient and their relative on the high dependency unit. They were universal in their praise for the staff on the unit. Reporting that they had been kept informed of everything that was going on. Although the patient did mention that they hadn't seen their consultant yet since admission to the unit.

Emotional support

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

Are critical care services responsive?

Requires improvement

We rated this service as requires improvement for responsive because:

- Patients on the level 2 HDU were often not reviewed by their parent consultant within 12 hours of their admission.
- There was a problem with delayed (both units) and out of hours discharges (HDU). The ICNARC data for July to September 2015 showed that 23% of the discharges from HDU occurred out of hours.

Service planning and delivery to meet the needs of local people

- In accordance with the 'healthier together' proposals for Greater Manchester, the Royal Oldham Hospital will become a specialist hospital, which will carry out more

emergency surgery. This will have implications for critical care services at ROH, which is likely to see an increase in the number of critical care beds. The various options for the on-going provision of critical care beds across the trust were still subject to discussion.
- There were bed management meetings held throughout the day to monitor and review the flow of patients through the hospital and this included the availability of critical care beds.

Meeting people's individual needs

- Patients on the HDU were not guaranteed to be reviewed by a consultant within 12 hours of their admission. On the HDU patients remained under the care of their parent team and did not have their care and treatment managed by intensivists or anaesthetists. A recent audit revealed that only 50% of patients on the HDU were reviewed by their consultant within 12 hours.
- We saw that when patients were admitted to the level 2 HDU beds directly from theatre, they were collected by the unit nurses. It was important that the collecting nurse made absolutely sure that all anticipated drugs and fluids were duly prescribed before leaving theatre as there was inevitably a delay before that patient would be seen on the unit by a doctor. We were told that this often led to patients not being formally 'clerked' in on their arrival to the unit. A clerking is a comprehensive history and full examination of a patient taken when the patient is admitted. This should include a review of initial investigations, any differential diagnoses and a management plan. Clerking is essential in ensuring that care is patient-centred.
- Care plans demonstrated that people's individual needs were taken into consideration before delivering nursing care.
- There was an outreach service within the hospital though this did not cover all wards and was not provided 24/7. The service covered all surgical wards, orthopaedics, gynaecology, labour ward and the medical assessment unit. The outreach team followed up all patients discharged from critical care.
- Interpreting services were available within the hospital if required.
- The latest available intensive care national audit and research centre (ICNARC) data showed that for the level 2 HDU unit the early readmission rate was better than comparable units but the late readmission rate and transfers out (clinical and non-clinical) were slightly worse than in comparable units. The level 3 ITU submitted its ICNARC data separately and it showed that for early and late readmissions the unit was now performing better than comparable units though for transfers out was performing worse than comparable units.
- The unit hosted the senior nurse for organ donation (SNOD) although this service covered three hospital sites within the trust. Occasionally, unit staff would assist in opening an additional bed to facilitate the admission and care of a patient who was to donate; this was financed by ring fenced organ donation monies. All patients for whom a decision to withdraw treatment was made were referred to the SNOD.

Access and flow

- The bed occupancy for the period September to December 2015 was 77% to 85% for the ITU and 91% to 93% for the HDU.
- Challenges with access and flow within the wider hospital impacted on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from critical care there was often a delay in discharge.
- The figures for April 2014 to March 2015 showed that 36% of patients on the level 3 ITU experienced a delayed discharge and 52% of patients on the level 2 HDU had their discharge delayed. The majority of the delays were between one and three days with the occasional patient waiting as long as a week. Delays in discharge beyond the 4 hour target meant that some patients experienced a breach in the single sex accommodation standard. Same-sex accommodation means patients and service users share sleeping accommodation, bathroom and toilet facilities only with people of the same-sex.
- In terms of out of hours discharges the ITU was performing much better than comparable units whereas in the HDU, the ICNARC data for July to September 2015 showed that 23% of the discharges occurred out of hours.
- As a consequence of access and flow issues within the hospital, during the 12 months from December 2014 to December 2015, 16 patients had been ventilated outside the critical care unit. This took place within the theatres when the patients were looked after by the duty anaesthetist supported by theatre recovery nurses and operating department practitioners.

Critical care

Learning from complaints and concerns

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

Are critical care services well-led?

Inadequate

We rated this service as inadequate for well-led because:

- Within both critical care units, ITU and HDU there were designated nurse leaders. However, whilst there was a designated clinical lead for the level 3 ITU, there was no similarly designated clinical medical lead for the level 2 HDU facility. The arrangements for admission, discharge, on-going management and responsibility for patient care was different for the level 2 HDU at ROH than for the trust's other critical care areas, as detailed in the trust's critical care operational policy (version 5).
- The risks associated with the patient pathway in the level 2 HDU at ROH were clearly known for several years and documented within the organisation. Recommendations and national guidelines had not been implemented to reduce these risks. There was a new triumvirate management team for critical care in the trust comprising medical, nursing and business managers however governance processes were still being developed and embedded.

Vision and strategy for this service

- As part of the 'healthier together initiative, the Royal Oldham Hospital had been chosen as one of Greater Manchester's 'specialist' hospital sites. The proposed changes and increase in surgical activity at the ROH will necessitate an increase in critical care provision. The trust has recognised in its five year strategy that there are several options for the re-configuration of critical care pathways and services across the whole trust and remain subject to debate and ultimately public consultation.

Governance, risk management and quality measurement

- When we asked senior staff within critical care what was their greatest risk, they all agreed that it was the patient pathway on the level 2 HDU at ROH.
- This was reflected on the critical care directorate risk register. An on-going risk recorded on 10/10/2011 stated that the risks associated with the HDU at ROH could 'potentially result in sub-optimal care'. It is not clear what steps had been taken to mitigate the risks associated with HDU as the risk register doesn't record any actions.
- We do know that in November/ December 2015 the new critical care directorate management triumvirate developed a paper outlining the investments required by the trust to address the current shortfalls in meeting the national critical care specification (D16) at ROH. It is not clear from reading the paper, what subsequent actions have been taken or progress made?
- The unit was subject to annual peer review benchmarking by the Greater Manchester Critical Care Network against the present evidence base and agreed standards for critical care provision. The most recent review by the network had been in May 2015. The network report identified some serious concerns especially around the patient pathway for level 2 patients at ROH.

- Governance processes in the critical care directorate were still evolving since the appointment of the new triumvirate management team. Critical care directorate meetings were held monthly and attended by the directorate's management triumvirate comprising, medical, nursing and business leads. The minutes of the October 2015 meeting state that there was still a need to appoint a governance lead for the directorate. It was not clear how the critical care risks were escalated within the organisation so that the board were aware of them.
- Performance reports were being produced monthly to demonstrate activity within the critical care units.
- Both units contributed data to the intensive care national audit and research centre (ICNARC).

Leadership of service

- There was no medical clinical leadership of the level 2 HDU. This impacted upon the patient experience in many ways with certain critical care standards not being met as a consequence. Patient experience in the HDU was often poorer than in the ITU as a consequence of this lack of medical leadership.
- There was a new triumvirate management team for critical care in the trust comprising medical, nursing and business managers.
- Nursing staff knew who their managers were. There was a designated lead nurse for the critical care units at ROH.
- Staff told us they had recently seen the chief nurse visit the units during the junior doctors' strike.

Culture within the service

- There had been an acceptance of the patient pathway concerns in HDU and the often associated sub-optimal care. This arose as a consequence of there being no designated medical leadership in HDU. A situation that had perpetuated for years with the trust failing to get a grip of the issues and address the shortfalls in the service.
- Staff were open, honest and happy to tell us what it was like to work in critical care.
- Staff were encouraged to report incidents and raise concerns.
- We asked staff about their understanding of 'duty of candour' and obtained mixed responses.
- Considering the pressures on the HDU staff and the risks associated with the level 2 patient pathway at ROH we asked if they ever turned to the adjoining level 3 unit for help, support and guidance. From a medical perspective it was said that this depended upon who was on duty.

Public engagement

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

Staff engagement

- In the wider trust, staff had been consulted and involved in co-creating the organisation's new values, new goals and new five year transformation plan.
- Staff on the level 2 HDU said that it was difficult to find time to have staff meetings.
- The trust had developed a range of communications to help to staff to celebrate their success such as the 'Pride in Pennine' publications, staff awards, Monday Message and the 'Pennine News' newsletter.

Innovation, improvement and sustainability

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

Critical care

- The critical care matron (based at North Manchester General) had developed an evidence based delirium strategy, which had been adopted by the critical care network.

Maternity and gynaecology

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

Information about the service

Royal Oldham Hospital is one of two hospital sites of The Pennine Acute trust which offers both outpatient and inpatient maternity and gynaecology services. The hospital provides pregnant women and their families antenatal, delivery and postnatal care. The department delivered 5219 babies in the past year. Inpatient and outpatient gynaecology services are offered at this site.

The Women's unit is situated on three floors of one wing of the hospital. There is a separate entrance with drop off parking for the delivery suite away from the main accident and emergency entrance. There is a consultant led delivery suite with 12 rooms, including one high dependency room and one birthing pool. There is a midwifery led birthing centre with five delivery rooms, three of which have a birthing pool. Ante-natal inpatient care is delivered on a 24 bedded ward and there is a 29 bedded post-natal ward. There are two obstetric theatres which are situated adjacent to the delivery suite with a three bedded recovery area. Maternity triage is situated in the main hospital on the ground floor. This had one bed, two couches and six reclining chairs.

The gynaecology endoscopy suite had two treatment rooms and a seated recovery area. The inpatient gynaecology ward has 28 beds five of which are designated for day case surgery.

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

We visited the maternity department during the announced inspection on the 25th of February 2016 and the 3rd of March 2016. We carried out an unannounced inspection on the 17th March 2016. During our visit we spoke with 38 staff, 3 patients and two family members. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 39 patients. We also looked at four medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as inadequate because:

- There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm. There was a failure to effectively investigate and learn from incidents with a lack of openness about outcomes.
- There was a lack of learning from complaints and a lack of learning and sharing of knowledge from discussions about mortality and morbidity.
- There was a lack of accurate record keeping including Early Warning Scores (EWS) for adults and neonates, consent forms and surgical safety checklists.
- There was a shortage of midwifery staff which led to some delays in transfers during labour and inductions of labour. There was high midwifery sickness and gaps in the consultant cover.
- There was a lack of actions to make identified improvements in audits of the quality of service provided had taken place. Mechanisms for collating data were not used to inform and improve practice.
- The security system on the post natal ward did not offer sufficient protection from abduction.
- Midwives and medical staff were not up to date with training and competence for some of the tasks they performed. Most staff were not up to date with appraisals of their performance.
- The average length of stay was longer than the trust's target.
- There was no strategy for continuous improvement or sustaining the changes which had been implemented following the focus on the maternity improvement plan which was developed following the external review in January 2015;.
- There was a lack of clear systems and processes for managing risks and performance of the service.
- There were few mechanisms for staff engagement and plans to improve. There was little encouragement for innovation from staff.
- A number of plans regarding public engagement had been postponed.

However:

- Some improvements had been made as a result of the maternity improvement plan including the purchase of necessary equipment.
- Midwifery and medical staff worked well as a team and provided compassionate care despite the shortage of staff.
- There was an enthusiasm amongst the staff to improve the services.
- The bed occupancy was lower than the England average and there were good processes in place for discharge of patients.
- Gynaecology procedures were provided on an outpatient basis and there was some innovation in this practice.
- There were changes in the leadership of the service following our inspection. Between the announced and unannounced inspection some practical changes had been made and staff told us there was already an improvement in communication.
- We were given assurance that immediate changes had taken place to address concerns about staffing levels which were raised during our inspection.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

We rated this service as inadequate for safe because:

- An independent review into nine serious incidents in the maternity services at the trust had been completed in January 2015. The recommendations made had not been put into practice in the management of incidents we reviewed.
- There was an unacceptable level of serious incidents with delays in investigations including those resulting in severe harm. There was a failure to effectively investigate and learn from incidents with a lack of openness about outcomes. The procedure for the management of incidents, including the investigations, was unclear to senior staff.
- There was a lack of learning and sharing of knowledge from discussions about mortality and morbidity.
- Specific training following previous poor clinical outcomes in infection rates had not remained up to date two years later.
- There was inconsistency in the completion of patient record keeping.
- Not all staff were up to date with mandatory training.
- The security system on the post natal ward did not offer sufficient protection from abduction.
- Records for the monitoring of patients, including neonates, to detect deterioration in their condition were not accurately completed. Records showed the recommended safety procedures for patients having surgical operations in theatre were not followed.
- The midwifery staff to patient ratio was worse than the England average and the labour ward frequently had lower than the planned number of midwives working. Midwives were not achieving one to one care in labour. Midwife sickness levels were high. Whilst there were some delays in patient care due to low staff numbers these were limited due to staff of all grades working extra hours and through their breaks to support patients. There were gaps in resident consultant cover for obstetric services.

However:

- The maternity services were visibly clean and infection prevention and control measures were in place. An increased amount of equipment, including monitors for assessing the health of the unborn baby, had been purchased as a result of the maternity improvement plan. The midwifery led birth centre offered a very homely environment.
- Medicines were safely stored and the required records were kept.
- The trust responded promptly and took appropriate action to mitigate immediate risks following our inspection. During our inspection a safeguarding concern was identified in the obstetric theatres and action had been taken to address this at the unannounced inspection. Changes to the staffing escalation procedure had been made to proactively respond to low staffing numbers.

Incidents

- An independent review into nine serious incidents in the maternity services at the trust had been completed in January 2015. Following this several recommendations were made about incident reporting. These included; clarifying the process for escalating concerns, a quality check for incident reports to ensure the root cause was clearly established, making recommendations clear and unambiguous and where individual failings had been identified, including leadership failings, reports must demonstrate education and training had been considered. These recommendations had not been put into practice in the management of incidents we reviewed. We saw reports with no recommendations or learning points recorded, staff, including senior managers, were unaware of the outcomes of serious incident investigations and the process for quality checking of reports was not understood by those completing investigations.
- In the past 12 months the trust had reported 32 serious incidents in maternity services. 21 of these had been reported retrospectively as the need to do so had not been identified at the time.
- There was a delay in the management of incidents in the maternity services. Information provided by the trust of analysis of incidents between 1 October 2014 and 21 February 2016 showed there were 170 unclosed incidents in maternity and gynaecology services. The majority of open incidents at 104 were in the labour

ward. At a trust level within the total of open incidents 44 involved moderate harm, eight severe and five death. This information was not separated into the two maternity hospital sites.

- Ward managers had a lack of protected management time and had a backlog of incidents to investigate.
- Failure in the management of incidents was on the maternity and gynaecology risk register. One of the actions to monitor this was "regular auditing of the process" which had a target date of 31 January 2016. At the time of the inspection no audits had taken place.
- Weekly meetings were held to discuss practice issues arising from incidents. Any midwives could attend and supervisors of midwives were encouraged to attend. The incidents were being discussed retrospectively and they were managing those which had occurred 12 months previously.
- Patient safety alerts from incidents which occurred in February and March 2016 were on display in labour ward and the latest was discussed during midwifery and medical handover.
- Changes to the guidelines for admission to the midwifery led birth centre had taken place as the result of an incident in 2014. These included the gestational age that a patient could be admitted and the monitoring which was required. Adherence to this had been audited twice with 100% compliance both times.
- In the maternity triage area staff said the sharing of information from incidents was improving with email communications, provision of written alerts and being shared at handover. This was not embedded and did not occur consistently in all areas.
- Staff knew how to report incidents. However some issues which should be reported as an incident had become accepted practice. Staff were unsure how they would obtain feedback from an incident they had reported and told us this did not always occur.
- There was no mechanism for learning from trust wide incidents. This meant if an incident occurred in another service which may affect practice in maternity services the learnings would not be shared with staff.
- A weekly multi-disciplinary meeting took place on the gynaecology endoscopy suite. This was to discuss any incidents with specimen labelling or results. They used this to learn from any errors which had taken place.
- There were 51 unclosed incidents in the gynaecology services within the trust. Of these three were graded as severe.
- The manager on the gynaecology ward said she did get feedback from incidents from the service matron. This was then cascaded to ward staff via the ward meetings.
- There was low attendance at the monthly multi-disciplinary mortality and morbidity meetings. Of 17 clinicians two attended five times in the past 12 months with the others attending less. There were five meetings of the past 12 when no midwifery managers attended. It was recorded that staff were expected to achieve 70% attendance however no clinicians met this target.
- Junior doctors presented cases at the monthly mortality and morbidity meetings with consultant support. They did not know how the outcomes of the discussions and presentations were recorded or used to learn any lessons.
- On the minutes of the trust wide mortality and morbidity meetings we reviewed up to January 2016 there were no actions noted on the presentation slides, none recorded in the corresponding section on the meeting spreadsheet and no lead consultant. This was the case despite learning points recorded which identified actions were required. This included guidelines not being followed and appropriate translators not being available during the night. The minutes for the January 2016 meeting showed improvement with all sections fully completed.
- Senior staff we spoke with were aware of the duty of candour; however we did not see recorded evidence of this since the documents for the incidents we requested did not contain information that the duty of candour had been followed.

Safety thermometer

- The specific maternity safety thermometer information was gathered from the post natal ward and community midwives. This information was not displayed. This is a point of care survey that is carried out on one day per month in each maternity service on all postnatal mothers and babies who consent to take part. Data provides a 'temperature check' on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for patients.

- Safety thermometer information from the trust showed in January 2016 there were 46 patients with perineal trauma and 47 in February. Seven patients had infections in January. Midwifery staff were unaware of this information and how it was to be shared or used.
- Harm free care information was on display on the antenatal ward. This showed there had been no incidences of harm the previous month. Additional maternity specific information was included such as the induction of labour rate at 30%.
- The "open and honest" care board on the gynaecology ward had not been fully completed. The section for the number of falls and the name of the nurse in charge were blank.

Cleanliness, infection control and hygiene

- All areas of the maternity service and the equipment were visibly clean.
- Waste segregation was appropriately managed in the clinical areas.
- The infection control information was displayed in the post natal ward. This showed for the previous month the score for the ward cleaning audit was 100% and 92% for the infection control audit.
- Hand gel was available at the entrance to all wards and departments. We observed staff using it and reminding visitors and patients to do the same.
- The trust did not provide specific hand hygiene audit data for this hospital site.
- Information provided by the trust showed there had been no MRSA or Clostridium Difficile in the maternity services between April and December 2015.
- Following higher than national incidences of puerperal sepsis in 2013 an action plan had been developed to ensure the rates were reduced. Aseptic non touch technique training was part of this plan. Information from the trust showed 75% of nursing and midwifery staff and 37% of staff in additional clinical services were up to date with this training. This meant not all staff who delivered care were up to date with this training. The trust was not compliant with this action they had identified to prevent puerperal sepsis.
- The service did not provide surgical site infection information. They told us "due to the nature of Obstetrics and Gynaecology surgery and associated short length of stay in hospital, this is not currently mandated for this speciality." However there was some ongoing consideration as to whether this information should be audited.

Environment and equipment

- One of the improvements from the maternity action plan was the purchase of new equipment. This included Cardiotogography monitors in every area. There was now one for every room in the labour ward and two for the theatres. This reduced the risk of a patient being transferred into theatre and having continuous monitoring interrupted.
- There was a business plan in place to introduce an electronic patient information system. This would provide all information required during childbirth when monitoring the health of the patient including fetal heart monitoring. This information is displayed on screens and can be accessed remotely improving timely decision making by clinicians.
- Adult resuscitation equipment was available in all clinical areas. Records showed these had been checked daily.
- Resuscitaires for neonatal resuscitation were present in the required areas. Records showed the checks of this equipment had not always been completed daily as per the trusts' policy.
- The necessary equipment to evacuate a patient from the birthing pools in an emergency was available in all rooms with a pool.
- The birthing pool water temperatures on the labour ward were written in the notes of the patient. They were checked prior to the patient entering the pool and during its use. On birth centre the temperatures were written on the patient's partogram within the designated space for the patient's own temperature. There was no clarity on the form of these separate records. The recording of the water temperatures in the birthing pool had been an action required as a result of an incident. No changes to the documentation or monitoring systems had been made.
- The bereavement room on the labour ward was not a designated room and therefore contained the usual medical equipment and furnishings. There were no additional facilities such as for families to be accommodated or get refreshments.
- The midwifery led birth centre had homely fixtures and fittings and was not clinical in appearance. There were

four rooms with a double bed which pulled down from the wall, adjustable soft lighting, non -clinical cots and three rooms had birthing pools. The décor was domestic in nature and the area was close enough to the maternity unit if required in an emergency, but was separate from the consultant led area. This area provided a very calm area for low risk patients.

Medicines

- Medicines were securely stored including intravenous fluids.
- Daily checks of controlled drugs by two people took place. These were recorded and records we reviewed showed they took place daily. A weekly check by the manager was recorded which provided additional oversight.
- The temperature checks of the medicine fridge had been completed daily.
- An electronic medicine administration system was used. The midwives had a portable medicine trolley and computer which was shared between the various accommodation bays on the ward.

Records

- Charts for fluid intake and output had not been fully completed. No totals were recorded to assess the overall fluid balance.
- Where necessary the risk assessments for tissue viability were completed for example following caesarean sections.
- The completion of care plans was inconsistent. In some patient records care plans were completed and in others they were present but were blank. This included for the management of peripheral vascular devices.
- We reviewed five patient records on the gynaecology ward. These varied in completeness with some records blank or only partially completed. These included no care plan documented for a patient with a catheter, fluid intake and output chart with only one output entry in 24 hours with no actions recorded and a record of nil by mouth two days previously with no oral or intravenous intake recorded since. The ward manager confirmed this patient was now taking oral fluids.
- On the gynaecology ward patient notes were not securely stored and were accessible to other patients and the general public. On the maternity wards records were securely stored.
- The “red books” for babies’ health records were used.

Safeguarding

- The trusts’ target of 90% of staff to be trained to level 2 in safeguarding children was met by the inpatient obstetrics and gynaecology services. However community midwives did not meet this target with 80% compliance. The target of 30% of staff to be trained in safeguarding children to level 3 was met by all staff in the obstetrics and gynaecology services.
- In the recovery area of the obstetric theatres there were three resuscitaires where babies were brought straight from theatre. Due to the urgency of treatment required this would be done without the babies being labelled therefore there was a risk of incorrect identification if two babies were in this area at the same time. At the unannounced inspection on 17 March 2016 a system of labelling the baby prior to leaving theatre had been introduced.
- A baby tagging system was in place which if triggered progressed to a security lock down of the relevant area.
- The system for access to the postnatal ward posed a risk to the security of patients and babies. There were two doors into the unit and there was a buzzer system with a camera for both. Staff should identify the caller and observe them through the camera before entry. Due to the location of the doors away from observation staff did not know if others had followed the identified person. We observed this to occur on all our visits to the ward. Due to open visiting for partners there were a large number of visitors entering and exiting this area. An incident had occurred in November 2015 where a baby had been taken from this ward and out of the hospital without authorisation. The entry and exit system had been identified as part of the cause; however staff said nothing had been changed as a result.
- The discharge of patients with complex social needs included input and advice from the community midwife who would be familiar with their circumstances and needs.
- Safeguarding information was easily identifiable in the patient records. These contained all the necessary information including contact telephone numbers.

Mandatory training

- We did not obtain an overall figure for the mandatory training in the maternity services. Information provided was split into the 11 subjects which made up this

training. 90% or more of staff were up to date in nine areas. These topics included hand hygiene assessment, equality and human rights and information governance. The trusts target of 90% was not reached in two areas with 80% of community midwives compliant in infection prevention and 67% of clinical staff up to date in health, safety and welfare level one.

- Whilst some specific training had been deemed to be mandatory, such as Cardiotogography (CTG), staff were not allocated time to complete this. Where this was e-learning it was accepted midwives would complete it in their own time. Information from the trust showed in December 2015 80% of midwifery staff had completed CTG training which did not meet the trusts' target of 95%. Medical staff were compliant with this target.
- There was a public health training day which included topics such as care of patients with a high body mass index (BMI), domestic violence and breast feeding. Maternity medical staff and midwives were expected to attend every two years.

Assessing and responding to patient risk

- We reviewed 30 Early warning score (EWS) records. 26% of those we saw had not been fully completed for example not all parameters checked, the frequency of observations not recorded and no date or time documented even when the score indicated an abnormal observation. As all the parameters were not completed the score could not be accurate and therefore the decision to escalate for medical review was based on insufficient information. One example was a patient in the high dependency unit whose temperature had not been recorded at every check.
- The guidance to obtain a medical review as a result of the EWS score was not always followed. We saw no medical review had been requested when a score was three, although guidance on the EWS said to contact a doctor within one hour if between three and five. The observations were not redone for one hour and at that time the overall score had reduced. However on other wards we saw examples of patients having a medical review within ten minutes when the score on their EWS indicated their condition had deteriorated.
- There was no neonatal early warning score used to detect deterioration in the condition of a new born. An observation chart was used; however this did not facilitate the observation outcomes to be calculated in order to identify an overall score. It did not meet the recommendations of the British Association of Perinatal Medicine (BAPM) which is that the tool should seek to "provide a visual prompt to aid identification of abnormal parameters by colour coding e.g. red, amber, and green". Midwives on the postnatal ward identified this as a concern especially since it was planned that nursery nurses would be responsible for completing and recording neonatal observations on the future. There were plans to introduce a score to meet this standard; however staff did not know any timescales.
- The five EWS records we reviewed on the gynaecology ward were mostly fully completed. However one had not had the total score completed despite showing a potential deterioration in the previous score.
- We reviewed five patient safety checklists following operative procedures. The record used varied in the files from a faint photocopy of a maternity patient safety checklist, to a complete copy of the same document and a peri-operative record which included some elements of the safety briefing. Midwifery managers discussed they were unclear which record should be used. None of the records we saw were fully completed. On another ward we were told they would be kept in a central file, however this was not located.
- The WHO briefing documents we reviewed were not fully completed. None of the 36 trust wide records we reviewed had the team debrief section completed. This had been raised as an area of concern at a labour ward forum. Since staff from the general theatre were working in the obstetric theatre it had improved.
- The World Health Organisations (WHO) safer surgery checklist had been adapted and was used in the gynaecology endoscopy unit prior to the procedures taking place.
- The high dependency room on the delivery suite was used for patients who required a greater degree of observation. We saw support was provided from intensive care staff if it was required. Should any patient require intensive care they would be transferred to the critical care unit in the general hospital.
- Midwives were using a "fresh eyes" approach for the review of CTG monitor recordings as recommended by the Royal College of Midwives.
- Telemetry was available which meant the fetal heart could be continuously monitored in the birthing pool if required.
- There was a system in place for midwives to check advice given by unqualified staff during telephone

triage. We saw records were countersigned to indicate this had occurred. The records for telephone calls contained prompts to obtain detailed information from the patient. These had changed in the past month to include more information.

- Patients with a BMI of over 35 were not accepted into the birth centre. If a patient was persistent a consultant and midwife would assess the individual risks.
- The need for a system to identify and assess risks and have a process of escalation for the maternity services as a whole was identified on the maternity improvement plan. A rounding tool was developed and used four times per day by the manager in charge to assess the risks and the measures needed to reduce them. This included high activity, low staff numbers or a patient with highly complex needs.

Midwifery staffing

- The numbers of midwives to birth ratio was worse than the England average. Managers were unclear how the figure had been calculated and a revised calculation of 1:34 was provided by the trust on 3 March 2016. The England average was 1:28.
- Information provided by the trust showed one to one care in established labour did not meet the 100% of births target between April and October 2015. The lowest was 94.9%.
- All the midwives and managers we spoke with stated staffing issues were their major concern for the maternity services. This had been recognised by the trust and the "failure to achieve safe staffing levels" was on the risk register. Managers used the red flag system to raise concerns about specific staffing levels.
- Midwifery staffing on the labour ward was reduced on most nights. To ensure there were sufficient staff to provide safe care staff were moved from the antenatal or post natal ward. Information from the trust showed in January 2016 the average fill rate at night for registered midwives on the labour ward was 102% but on the postnatal ward it was 90.3%.
- During our inspection staff had requested to divert patients from the labour ward one night due to there being seven midwives instead of nine. There was a high level of activity including deteriorating patients and both obstetric theatres in use. Despite all avenues to increase the staff numbers being unsuccessful this divert was not approved by the on call manager. Midwives had escalated their concerns that this was unsafe to the manager on call. Following our inspection implementation of the escalation policy was reviewed and assurances given that it would be used proactively when activity on the wards was assessed every four hours or between if necessary.
- There was a high rate of sickness at 7.08% of midwifery registered staff in the past financial year. In the same period sickness rates had been 15.59% of unqualified maternity staff and 3.37% of community midwives. At the time of our inspection there were six full time staff sick on the labour ward and 9% sickness on the post natal ward.
- The band 7 co-ordinator on the labour ward had to work clinically when the ward was short of staff. After 5pm they were also the co-ordinator for the maternity unit and had responsibility for assessing the acuity of the other wards to co-ordinate the staffing.
- On the rota for the labour ward from 7 March to 3 April 2016 there were 156 vacant shifts. One staff member had rung 30 staff in one day to try and fill these by asking bank staff or ward staff to work extra hours, swapping day to night shifts and cancelling other commitments such as training. If they could not be filled this way agency staff would be used**.**
- The reduced number of midwives on the labour ward was further depleted when midwives assisted in theatre. This had been recognised and an agency "scrub" nurse was employed to work 8pm to 8am. At the unannounced inspection on 17 March 2016 this had been extended to include an agency "scrub" nurse on the days elective caesarean sections were booked. Further action to increase this cover was taken following the inspection.
- Due to midwifery staff shortages delays in patient care did occur. While we were on inspection one elective caesarean section was deferred to the following day.
- Two midwives were present 24 hours per day in the midwifery led birth centre. Midwives were available on call in the community to attend the centre if required.
- A band 7 ward manager had recently been introduced to co-ordinate the care in the birth centre.
- For week commencing 31 January 2016 there were four shifts with one midwife and not the planned two in the triage unit. We observed escalation of shortage of staff in this unit and a second midwife being redeployed to that area.

- In the triage area there were 41 vacant shifts for March 2016 when the electronic roster was completed. Staff would change shifts and work extra to try and cover these shifts
- 28 health care assistants had been recruited. Whilst midwives told us this was beneficial they had been unclear about their role and they had not received training in maternity care when they started their positions.
- At night midwives worked 12.5 hours and were paid for 10.5 hours despite them not getting their break.
- Staff moved between wards to cover staff shortages part way through a shift which resulted in no consistency for the patients.
- Although shift handover on the labour ward was attended by medical and midwifery staff there was no input by medical staff into the midwifery handover. The labour ward manager was present at the medical handover and shared a patient safety alert at that time.
- Midwives moved from the birth centre to the labour ward if required as part of the escalation plan. Should this occur at night as it would mean a community midwife on call needing to attend and work in the birth centre. This impacted on their visits in the community and running of antenatal clinics the following day.
- Actual nurse staffing on the gynaecology ward usually met the planned numbers. In November 2015 the average staffing was 3.4 registered nurses against the planned of 3.6. The night staffing met the planned numbers throughout the month.
- Nurse staff sickness on the gynaecology ward was 13%. We observed this had an effect on the staff numbers as they had three qualified nurses instead of the planned four.
- Agency use on this ward had been high at 18% in March 2015; however there had been no agency use in November 2015.
- Nurse staffing in the gynaecology endoscopy suite meant patients could be unobserved for a considerable time in the recovery area, following a procedure. These patients would not have had a general anaesthetic, but may feel unwell due to the nature of their treatment. We saw staff from the gynaecology outpatient clinic cover this area when they were able.

Medical staffing

- Information from the trust showed that there had been 135 hours of consultant cover on the labour ward to June 2015. In the past 12 months there had been 5219 births which meant they should have 168 hours cover to meet the 2010 Royal college of Obstetrics and Gynaecology guidelines. Following our inspection to the trust confirmed they would review the consultant workforce to provide more consultant cover at the Oldham site. This would be fully implemented in August 2016.
- Doctors told us they were concerned about gaps in the consultant resident on call rota on Friday evenings. There was a twilight shift 5pm to 8.30pm from Monday to Thursday; however there was no resident cover for this shift on a Friday. There was a consultant present from 9am to 12pm Saturday and Sunday. A consultant was on call from home and two middle grade doctors provided resident cover. Following the inspection the trust confirmed this shift would be covered as a matter of urgency.
- Midwives told us there could be delays in medical reviews for patients on the post natal wards. This was in part due to the complexity of the needs of the patients and the need for junior doctors to seek advice and support
- There were no delays in accessing medical review in the maternity triage unit. They had a doctor assigned to that unit and usually had registrar cover.
- There was always a doctor available on the gynaecology assessment unit. This was covered by a consultant or registrar between 8am and 8pm.
- There was good medical cover on the gynaecology ward from 8.30am to 4.30am. Outside of these hours a junior doctor and a registrar were on call.
- There was a medical ward round on the gynaecology ward every day by the on call consultant.
- There was consultant obstetric anaesthetic cover daily between 8am and 6pm with dedicated cover outside of those hours by a specialist registrar.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Maternity and gynaecology

Requires improvement

We rated maternity and gynaecology services requires improvement for effective because:

- Information collated on the maternity dashboard was not used to inform or improve practice.
- There were delays in the induction of labour due to staffing and capacity issues.
- Audits had taken place; however when improvements were required actions had not always been identified and where they had they had not been implemented.
- The trust had set targets for the outcomes for patients and the performance against these was mixed. Where they were not met staff were unable to tell us what actions were being taken to improve them.
- Midwives were not up to date with training for some of the tasks they were completing and there was no assessment of their competence for others. Staff appraisals were not up to date in most areas of the maternity and gynaecology services.
- Patients did not always receive pain relief in a timely manner.
- The consent to surgical procedure documentation was not fully completed.

However:

- Policies and procedures were in line with NICE guidance and were up to date.
- There was good support for infant feeding and patients were complimentary about the tongue tie service.
- There was good multi-disciplinary working.
- There was access to emergency gynaecology services seven days per week.

Evidence-based care and treatment

- The trusts' "Maternity care pathway and operational policy" was an overarching policy for maternity services which had been developed in February 2016. This policy replaced those from the individual units which had been amalgamated into the one trust since 2010. This policy was aimed as a guide to staff in the clinical pathway and day to day working of the maternity services.
- This document provided links to other policies such as the safeguarding and clinical record keeping policies.
- Policies and procedures such as antenatal care and induction of labour were in line with NICE guidance.
- There was no specific support for patients with a high body mass index including support to adopt a healthier lifestyle although this was part of the NICE recommendations. There was no specialist antenatal clinic or midwife for this group of patients.
- There was no enhanced recovery pathway for patients following an elective caesarean section.
- An audit of the EWS had taken place in May 2015. This had been conducted as a result of the external review of maternity services. This highlighted "a failure by midwifery and obstetric staff to follow clinical guidelines relating to standards for patient observations including the track and trigger system of physiological observation reporting". One of the recommendations was further audits should take place on a monthly basis by ward managers. One further audit had been completed in October 2015 and following this the audit tool was adapted. None of the midwifery staff we spoke with were aware of the outcomes or changes to practice as a result of these audits.
- During induction of labour patients could be delayed due to staffing shortages and not being able to move to the labour ward. Senior medical personnel gave examples of delays which caused patients to be unnecessarily in labour for 30 hours. This did not fit with NICE guidance for intrapartum care. We were told these incidents would be escalated to the senior obstetric managers.
- Information was collated on the maternity dashboard such as modes of delivery, post- partum haemorrhage rates and staff training. There was a lot of useful information stored however medical consultants and midwifery managers told us they were unaware how this was used to inform practice.
- The content of the maternity dashboard was discussed at the monthly quality and performance committee meetings. These were trust wide meetings for the women's and children's directorate. On the minutes we saw these discussions concerned the data to be collected and working with other agencies to collate data and not the outcomes indicated by it. Charts had been developed, in the past four months, to illicit trends from the data. There was no discussion around this in the information we saw.

Maternity and gynaecology

- At the monthly quality and performance meetings the gynaecology dashboard was discussed including information against targets such as the referral to treatment and cancer wait times.
- There was an audit programme for gynaecology services. This included clinical audits such as quality assurance for surgical termination of pregnancy and audit of activity such as the timings of doctor's attendance on wards.
- There was an annual audit plan for the anaesthetic departments which included obstetric anaesthetic services. Completed audits in the past 12 months included record keeping and emergency equipment.
- An audit of the anaesthetist response times for Category one and two (emergency) caesarean sections had been completed in 2014. The outcome was "we failed to meet the audit target of more than 90% of our caesarean deliveries being either less than 30 minutes for category 1 at 85% or less than 75 minutes for category 2 at 80%." Despite there being six recommendations there was no action plan developed to improve the outcome. This audit had not been repeated.
- Anaesthetic protocols such as that for a major haemorrhage were up to date and in line with current guidance.

Pain relief

- A patient's level of pain was assessed. There was a pain score on the early warning score and in the records we reviewed these had been completed.
- Patients were offered a variety of pain relief including oral, medical gas and epidural analgesia.
- Patients did not always receive their pain relief when they needed it. A face to face survey was completed on the post natal ward in September 2015 and nine of the 37 patients asked said they had to wait for pain relief. The action plan document for this survey was blank.
- The anaesthetist support meant a doctor was available to administer epidural pain relief within 30 minutes of request which met NICE guidance
- In the midwifery led birth centre 18 midwives had been trained to use hypnobirthing which is designed to reduce fear of childbirth and aid the relief of pain naturally.
- A bath was available for pain relief on the antenatal ward should patients wish to use this.

Nutrition and hydration

- The trust had been awarded stage 3 Baby friendly accreditation. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. This was due for reassessment.
- There was an infant feeding co-ordinator who worked 8am to 4pm Monday to Friday across the trust and a support worker. There were also volunteers who supported new mothers seven days per week. This support included those experiencing difficulties feeding their babies, mothers with babies on the special care baby unit who needed to express their milk and any other infant feeding issues which occurred
- Meals for patients were delivered to the ward and heated up individually at meal times. A hostess was employed from 10am to carry out meal provision.
- Specialist diets for health and cultural reasons could be obtained. This included low sodium, gluten free and halal.
- A survey of patients on the post natal ward in September 2015 showed a mixed reaction to the food. There were positive comments about the choice and flavour but some negative comments about the food not being hot enough and there being inconsistency about some patients being able to bring in their own food and others not.
- A tongue tie clinic was held and the infant feeding support workers could refer patients to that clinic. There was a three week waiting list for this clinic which could mean babies had difficulties feeding throughout that time. The breast feeding co-ordinator was training to carry out tongue tie procedures.
- 134 patients who used the tongue tie clinic completed a survey between July and September 2015. 132 were extremely likely to recommend this service to others.
- Infant milk was labelled and stored in a locked room.

Patient outcomes

- The process for completing elective caesarean sections had been changed so that there was an operating list all day on Monday, Wednesday and Friday to accommodate them. This made it easier to plan for adequate staff numbers on those days and there were no cancellations recorded.

Maternity and gynaecology

- The normal delivery rate target of 65% had been not been met for nine months April to December 2015. The rates remained slightly below this target at between 62% and 63% except for one month which fell to 58.7%.
- The Elective caesarean section rate of less than 10% of total births had not been met in seven of the nine months April to December 2015. In three of these months it had been flagged as a high risk with the highest rate at 13.2%.
- The emergency caesarean section rate was higher than the trusts' target. It had been in the high risk category on six occasions with the highest being 18.9%. It had been below the target of less than 15% of total births in one of the nine months.
- Inductions of labour were over the trusts' target of less than 27% of total births in all of the nine months reported on the dashboard. These had increased to the highest rate of 34.2% in December 2015.
- Staff reported delays in meeting the National standard of a patients' first booking appointment by 12+6 week. Reasons for this had been discussed at the monthly quality and performance meetings and actions to address it were to be identified.
- The total number of stillbirths was higher than the target of less than 4 per 1000 in one of the nine months.
- The incidence of patients having skin to skin contact following the birth of their baby was below the 75% target every month. This had increased from 62.6% in April 2015 to 72.9% in December 2015. Midwives told us they were aware of this but there was no specific action plan in place to improve this outcome.
- Maternal admissions to intensive care met the trusts' target for eight out of nine months.
- Patients who had a post-partum haemorrhage of greater than 1000mls was below the trusts' target of 10% for all nine months.
- Six patients had a post-partum hysterectomy in the nine month period April to December 2015. These would be investigated as an incident.
- 20% of patients who were in labour were transferred from the midwifery led birth centre to the consultant led labour ward.
- 18% of births were in the midwifery led birth unit.
- The home birth rate was 3%.
- Two of the three relevant standards from the national neonatal audit programme 2014 were met. Not all eligible babies were receiving retinopathy screening within the required timescale.
- Patients could have minor gynaecology procedures at the same time as hysteroscopy which resulted in a reduction in patients appointments.

Competent staff

- 88% of medical staff and 90% of midwifery staff were up to date with PROMPT training (PRractical Obstetric Multi Professional Training). This did not meet the trusts' target of 95%. As part of the maternity improvement plan an audit of PROMPT training and addition to the mandatory training had been completed. An additional action of reviewing the content of the course had been added; however there was no action to ensure all staff were up to date. Failure to meet this target was on the service risk register as there was recognition that high sickness and absence reduced attendance.
- The ratio of supervisors of midwives to midwives was 1:15 which met the required standard.
- In June 2015 the local supervisor of midwives audit report highlighted that less than 80% of supervisors of midwives were up to date with their post registration education and practice standards activities. This did not meet the required standard.
- Some supervisors of midwives had relinquished this post due to an inability to fulfil the role adequately. The requirement for 80% attendance of supervisors of midwives at team meetings had not been met at the last audit.
- A cohort of midwives had completed training in critical care at Salford University. They could provide the necessary level of support to patients in the high dependency unit on the labour ward.
- Band 7 midwives were trained in neonatal life support.
- For elective caesarean sections operating department personnel assisted in theatre and the recovery room.
- There was no competence assessment or refresher training for midwives who had completed their "scrub" training many years ago. Two midwives had completed this training eight years ago by watching other midwives complete the procedure. They had not had any training in the main theatre and never had a competence assessment or refresher training. They had been responsible for training other midwives.
- The nursery nurses who had been employed to work on the post natal wards had completed a training course in the "compromised baby".
- There was a practice education midwife two days per week. Managers told us this had a negative impact on

the pace of change as there was no lead for education and it was a part of their role. The need for more structured practice development had been discussed as part of the maternity improvement plan; however no actions had been taken.
- Staff should attend a study day for the management of high risk patients which was presented by the critical care outreach team.
- There was a cohort of core midwives on the antenatal and postnatal wards. They rotated for one month to the labour ward on agreement with their manager. This helped them keep up their skills for assisting at deliveries.
- Community midwives told us as part of the escalation procedure they had been asked to work on the labour ward. They had discussed their lack of competence to do this at the time as for one midwife it had been 14 years since they had assisted at a birth.
- Midwives had a two week supernumerary induction when they started on the birth centre.
- Staff in the maternity and gynaecology services were not up to date with their appraisals. 46.8% of nursing and midwifery staff and 21% of additional clinical services staff in the maternity services were up to date with their appraisals. 100% of midwives in the birth centre and 92.31% of community midwives were up to date. No nurses on the gynaecology ward were up to date with their appraisals.

Multidisciplinary working

- Midwives and doctors in the maternity services described good team working. We saw open communication with sharing of information and joint decision making.
- A monthly multi-disciplinary meeting took place on the postnatal ward. This included neonatologists, ward managers, community matron, assistant practitioners and neonatal unit manager.
- Midwives could obtain advice and support from the intensive care specialist team should they require this for patients in the high dependency unit.
- Midwives on the antenatal triage area and the postnatal ward described good joint working with the community midwives. They could access them by phone to discuss any concerns or queries they might have about a patient or to request a follow up visit.
- Public health team meetings took place every six to eight weeks. The public health midwives such as the teenage pregnancy support midwives and the screening midwives attended these meetings.
- There was no multi-disciplinary handover in the labour ward. Although doctors and midwives were present together they did not interact with the handover.
- Specialist nurses delivered gynaecology services. This included colposcopies and hysteroscopy.
- Nurses in the gynaecology suite and laboratory staff met monthly to discuss the processes for specimen management. This included histology, cytology and rapid response results.
- There was good multi-disciplinary working between the nurses in the gynaecology outpatient and endoscopy suite and the urologists. If necessary a patient would have rapid access to the urology clinic from the colposcopy clinic.
- A McMillan nurse provided support to oncology patients on the gynaecology ward.
- We observed support from allied health professionals when required such as physiotherapy for a patient in the high dependency unit on the labour ward.

Seven-day services

- Maternity triage facilities were available 24 hours per day seven days per week.
- The ante-natal day unit was open 9am to 5pm Monday to Friday. Between those times if patients required treatment which could not wait, such as urgent blood tests, they would attend the antenatal ward or triage area.
- The gynaecology assessment unit was open seven days per week from 8am to 8pm.
- There were no gynaecology clinics held at weekends.

Access to information

- There were some records currently being duplicated as an electronic system of record keeping was introduced. This increased the time it took to record some care interventions and for staff to locate some records as they were becoming familiar with the new systems.
- The electronic patient records did not allow for information prior to April 2014 to be accessed. Therefore information for any pregnancies previous to that date, which needs to be added to the patient's history information, would have to be accessed from an alternative electronic record.

Maternity and gynaecology

- The majority of "booking appointments" (the first appointment for a pregnant woman) were completed in their own home. Midwives did not have hand held computers so this information was duplicated by them recording handwritten versions with the patient and transferring the information to computers at a later date.
- There were information screens which could be used to record and display information such as bed occupancy. The user could access the information from other parts of the maternity units for example from labour ward to see if there were vacant beds on the post natal ward. Not all staff were using these screens and they were unsure if they could be used to store more information which could be useful in managing the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed six consent forms. The documentation consisted of a pre-printed form which required the consenting doctor to indicate some specific treatment options and discussion via tick boxes. None of the consent forms were accurately completed. Examples were no indication that the a general or regional anaesthetic had been agreed, patients name not printed or dated and pre-printed patient labels not present on each copy.
- Verbal consent had been recorded in patients' notes when an emergency caesarean section had been completed.
- There was no record of discussion and verbal consent to progress to a post-partum hysterectomy despite the patient having a regional anaesthetic and therefore able to consent. Doctors told us a discussion did take place; however this was not documented.
- Where English was not a patients' first language and there were concerns that they required information in their own language to make an informed choice they were provided with an interpreter. Where possible this was face to face and all staff understood the need to ensure this was carried out, unless there was an emergency situation.
- Staff understood their responsibilities under the mental capacity act.

Are maternity and gynaecology services caring?

Good

We rated maternity and gynaecology services good for caring because:

- Midwives were respectful, caring and considerate to patients and their families. They made sure they gave advice and support in a way the patient would understand and listened to them and their concerns. They protected patients' privacy and dignity.
- Patients and relatives were complimentary about staff and the care they had received.
- The trust scored the same as the England average in the friends and family test and in line with other trusts in the CQC maternity survey.
- Partners were involved in their maternity care and able to stay on the post natal ward. Choices were discussed such as opting for midwifery or consultant led care and discussions took place if changes occurred which meant these options were no longer available.
- Emotional support was available for patients who had additional support needs or had bereavement. Despite staff being very busy they gave patients time to discuss their concerns and were patient.

Compassionate care

- Patients spoke highly of the care and treatment they had received. They described staff as caring and thoughtful.
- We observed staff speak to patients and their families in a respectful and considerate way. When they were handing over information about patients they used dignified language.
- The organisation of the antenatal screening clinics meant if a patient had a fetal anomaly identified on their scan and following consultation opted for a termination there was a lack of room availability and doctors to sign the consent forms that they may have to wait with other patients. Staff would do all they could in this situation, including additional non clinical staff assisting if it would help the patient.
- The trust performed in line with or above the England average for percentage recommend for three of the four areas of the friends and family test between July 2014 and October 2015.

Maternity and gynaecology

- The trust scored about the same as others for all 17 questions in the CQC maternity survey 2015.
- Volunteers had carried out face to face interviews with 37 patients on the post natal ward in September and November 2015. The questions were around the quality of the care provided and most responses were positive. Comments included “staff were very helpful” and “always to hand”.
- During this survey patients had commented that staff were very busy, but despite this had provided a high level of care.

Understanding and involvement of patients and those close to them

- Partners were able to stay on the antenatal ward overnight and a single room would be provided if possible.
- Patients told us they had been kept informed about the care and treatment options and been involved in decision making about the birth of their baby. They told us staff had discussed any concerns in a way which they understood.
- One patient who had experienced difficulties in her first pregnancy discussed how the risks with her second pregnancy had been discussed and well managed. She had received “good support” from her consultant.
- Patients appreciated consistency of midwife and consultant where this had occurred throughout their pregnancy.
- Those patients who were unable to use the birth centre if that had been planned but their circumstances changed had this fully explained prior to them being admitted.

Emotional support

- There was a specialist bereavement midwife who worked part-time in that role.
- Midwives attended a bereavement study day once every two years to help them better support any bereaved patients.
- There were arrangements to ensure the privacy of patients who had a miscarriage. This included provision of private rooms on the gynaecology assessment unit and sensitive offering of support and aftercare.
- At the first “booking” appointment the mental health of a patient was discussed and written information provided regarding their emotional wellbeing throughout the pregnancy was given.
- There was a specialist midwife who provided additional support for those patients with mental health problems.
- Midwives had information to provide to patients to signpost them to additional support services if these were required.

Are maternity and gynaecology services responsive?

Requires improvement

We rated maternity and gynaecology services requires improvement for responsive because:

- The termination of pregnancy service had been suspended at short notice with no plans for reinstating this. Local services at other hospital sites had ceased resulting in increased travel for patients.
- There was no specialist foetal medicine service which meant patients had to travel to access this at another trust
- The average length of stay on maternity wards was longer than the trusts’ target with delays in discharges from the postnatal ward, especially out of hours.
- There was a delay in patients receiving results from gynaecology diagnostic screening.
- There was no system across the service for sharing lessons learnt from complaints.

However:

- The bed occupancy was lower than the England average.
- The referral to treatment times and the waiting times for the cancer pathway in gynaecology were met.
- Translation services were accessible in a timely way and specialist midwives were available to offer support and advice.

Service planning and delivery to meet the needs of local people

- The termination of pregnancy service had been suspended in December 2015. This was due to the absence of clerical staff. Nursing staff were unaware of the plans to have this re-instated. Patients had to be referred to the local private provider with the loss of this service. Termination of pregnancy for fetal anomalies was provided by the trust.

- Gynaecology clinics were only held at one community location. Patients had to attend Royal Oldham hospital for gynaecology speciality clinics and minor procedures.
- The early pregnancy service at Rochdale had been suspended which meant patients had to travel to bury to access this service.

Access and flow

- Patients could self-refer to the triage area or were referred by their community midwife, G.P. or Accident and emergency. Midwives felt this area worked well in terms of prompt medical review and midwifery discharges if required meaning patients did not experience extended waiting times.
- Between 40 and 50 patients per day were seen in the triage unit with an additional 10 to 15 in the antenatal day unit. Midwives felt some of the reasons patients attended could be managed by their GP or community midwife.
- The antenatal day unit was open 9am to 5pm Monday to Friday for patients with booked appointments for diagnostic tests such as blood tests.
- Changes to the management of the elective caesarean sections included the introduction of all day lists on three days per week. This had improved the service for patients and reduced the cancellations late on the arranged day which used to occur.
- 25 gynaecology operations had been cancelled on the day of the operation between August 2015 and January 2016. All of these had been rebooked within 28 days.
- The system for inductions of labour had been reviewed to improve the access for patients. Five inductions per day were planned and the admissions of these patients were staggered throughout the day, prioritised by risk. This meant not all patients labour was progressing at the same stage.
- In the afternoon the consultant would review the patients for induction of labour and if activity was high on the unit or there were staff shortages they would be deferred to the next day.
- Post natal patients were accommodated on the antenatal ward if there were capacity issues on the postnatal ward. These would be low risk patients for example not requiring intravenous antibiotics.
- There could be delays in discharging patients from the post natal ward out of hours due to waiting for a paediatrician to complete the examination of the new-born. Every attempt to complete it prior to discharge was made, although it could be completed by the community midwives if the check was not completed .
- Bed occupancy rates were lower than the England average.
- The average length of stay for patients following delivery was 3.2 days between April and December 2015. For those who had been admitted for reasons other than to deliver their baby the average stay was 2.8 days. This was over the trusts' target of 1.5 days. Those who delivered in the birth centre were within the trusts' target.
- Information provided by the trust showed the gynaecology outpatients were meeting the referral to treatment times for 99.1% of patients in the non-admitted pathway.
- 95.9% of gynaecology patients were seen within two weeks if they were on the cancer pathway. The decision to treat target was met for 97.7% of these patients.
- There were specific clinics held for gynaecology oncology which included a rapid access oncology clinic.
- The nurse lead in the gynaecology endoscopy unit was concerned the waiting times had increased due to a lack of clerical support. There were 25 hours administration time for the nurse led hysteroscopy service which led to delays in the management of appointments and the waiting lists.
- There were delays in patients receiving their letters following gynaecology procedures as an outpatient. The trust was 74.6% compliant with their own target. This was due to reduced administration support. We saw that results from tests taken on 28 January were available on the 22 February; however on the 3 March 2016 the letter to the patient had not been sent.
- If there was a shortage of staff on the gynaecology ward this meant there was no shift co-ordinator who provided oversight and assistance to ensure timely discharge of patients. Without a nurse able to work in this role there could be delays in the discharge of patients
- There were patients accommodated on the gynaecology ward from other specialities, due to a shortage of capacity on those wards. This included medical, general surgical and orthopaedic patients. Staff on the ward said there was not usually delays in these patients being reviewed by doctors from their own speciality

Maternity and gynaecology

Meeting people's individual needs

- All written information and patient leaflets were in English. There was a large proportion of the patients for whom English was not their first language. Staff said they could obtain leaflets in other languages; however there could be a delay in obtaining these.
- There was easy and quick access to translation services which included face to face translation when required. The midwives and doctors we spoke with understood the need for face to face translation with the majority of their patients to ensure a clear understanding of complex information.
- Young patients were allocated a specialist midwife who supported them throughout their pregnancy including providing parent craft sessions.
- The specialist mental health midwife was available to visit patients on the ward prior to discharge. They were also accessible for midwives to contact and obtain advice.
- There were a range of speciality gynaecology clinics which meant patients received specific advice and support from staff who were familiar with their needs. These included post-menopausal and endometriosis.
- There were gynaecology specialist nurses including gynaecology oncology and a link nurse for palliative care.

Learning from complaints and concerns

- Between 1 December 2015 and 31 December 2015 there were 47 complaints for maternity and gynaecology services. This represented 56% of the total for these services trust wide. The majority of these were about clinical care and treatment.
- Trust wide information showed that on average it took 139 days to close a complaint.
- Complaints were discussed at the women's and children's quality and performance committee meetings. We saw discussions included the numbers of new complaints, any themes and issues such as meeting timescales for responses.
- There was no consistent process for staff receiving feedback from lessons learnt from complaints. In some areas they told us they had this if they had been involved and in others that they did not get any feedback. In the meeting minutes of October 2015 it was documented that "clear lessons learnt need to be documented explaining what was done and how we changed things.
- Information about how to make a complaint was displayed in the maternity services. This was in English and leaflets would have to be requested in another language. This meant people for whom English was not their first language may not understand how to complain.
- There had been one written complaint in the previous 12 months in the gynaecology outpatient and endoscopy suite. The manager of this service had investigated and responded in a timely manner.

Are maternity and gynaecology services well-led?

Inadequate

We rated maternity and gynaecology services inadequate for well led because:

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

However:

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

- The maternity improvement plan was overseen within the trust by the gold meeting which was chaired by the chief nurse and medical director and incident management group jointly chaired by the chief nurse and CCG chair. There was also project management support provided by the trust internal patient safety team. This was audited to provide further assurance to the management group.
- The midwives with roles in governance and risk management told us their role and position within the organisation was unclear. They had not been part of management meetings until the past two months and if they raised concerns they were listened to however there was a lack of resulting actions.
- The link midwife with the lead for the improvement plan had 10 hours per week for this role. There was also an interim post filled by an external post holder which was full time.
- Governance of the maternity and gynaecology services was led by the women and children's division triumvirate. Senior staff were unclear how this worked in terms of their role in the management of the performance of the service. One manager recently appointed told us they should be part of this management group but had not so far been informed how this would work.
- There was a risk register for the maternity and gynaecology service. This had 11 risks documented with four being high risk. Controls, gaps and actions were recorded with target dates. Two of the risks were dated 2013 with the remaining nine dated between 15 December and 21 December 2015.
- Managers in some areas told us they did not have the protected time they required to ensure they could complete their management duties. They should have one day per week allocated; however this was not protected from clinical work due to low staffing numbers.
- Examples were given where financial considerations took precedent over clinical needs. This included the development of practice education and rolling recruitment advertising.
- There were monthly gynaecology governance meetings. They included the lead consultant, manager of the inpatient ward and the risk manager. At these meetings the risk register, serious incidents and general management of the service were discussed.
- The lead nurse in the gynaecology endoscopy suite was not included in the gynaecology governance meetings. They had expressed a wish to be part of the gynaecology divisional meetings but this had not yet taken place.
- The obstetrics and gynaecology consultants did not meet as a group.

Leadership of service

- The matrons were visible and staff told us they offered a high level of support when it was required. In the maternity triage area the matron visited every morning to assess the workload.
- Staff in all areas told us they did not see the midwifery lead often. Although they reported having seen other leaders in the service more frequently.
- A matron's meeting took place weekly. Discussion about the operational management of the units and the maternity services as a whole took place during these meetings.

- The matrons had met with the chief nurse and director of midwifery in November 2015. They had asked for a follow up meeting however that had not taken place at the time of the inspection.
- We were told the leadership of the service was reactive rather than proactive. One example was an email the week of our inspection to inform matrons they must attend the shift handovers on the wards.
- The midwifery senior management meetings were described as not inclusive, but rather a one way flow of information from the senior managers.
- There was a leadership programme for band 7 and 8 midwives. They were supported by the trust to complete this training over one year. However some told us due to the staffing shortages they could not put what they were learning into practice.
- Midwives were complimentary about the leadership for their specific area. The community midwives and those in the birth centre discussed good support including working with the staff when required and a "firm but fair" approach.
- Midwives told us at night and weekends there was no management presence in the maternity services. There was no on-call system to enable staff to obtain operational support from a midwifery manager. There was a supervisor of midwives on call for professional support if required.

Culture within the service

- Staff of all grades told us morale in the maternity services was low. The key reasons for this were cited as a shortage of staff, lack of communication and no positive reinforcement from trust management for the service they provided.
- Failure to improve staff morale across maternity services in the trust was on the risk register since 2013. The documented gaps in the control for this risk were "lack of consistent communication, lack of senior management visibility and lack of feedback". There were three actions to address this which included a staff engagement programme and back to the floor implementation. This was due for review in March 2016. During our inspection no staff we spoke with were aware of any of these measures being in place.
- Although the culture of the service was not as open as the staff would wish all those we spoke with said they would raise concerns. However when they had done so there had been little improvement or change.

Public engagement

- The inaugural meeting of the new maternity services liaison committee hosted by Pennine Acute Trust (PAT) to cover the PAT geographical area took place on 14 October 2015. A name change from Maternity Services Liaison Committee to Maternity Listening and Action Group was agreed along with forthcoming dates for the bimonthly meetings. It was agreed the most important element was for patients to discuss their experiences so lessons could be learned.
- Public engagement sessions were to take place as part of the maternity improvement plan. The planning of these was discussed 12 August 2015. On 9 September it was documented that the next step was to arrange community locality meetings to include Healthwatch. This had not taken place at the time of our inspection.
- As a result of feedback from patients a hot drinks trolley had been provided on the antenatal ward. This was part of the "You said/ we did" campaign.

Staff engagement

- Medical staff and midwives of all grades including managers told us there had been no feedback following the external review of maternity services and they had not been consulted during the development of the maternity improvement plan. They did now attend the weekly improvement meetings when they were able but these had begun after the initial plan had been developed.
- A copy of the maternity improvement plan was displayed on the notice board in the labour ward. In other areas staff had not seen the plan; they had seen some improvement messages and some had attended the weekly meetings.
- The supervisors of midwives had met and discussed how to incorporate the changes required from the local supervisors audit into the maternity improvement plan.
- The first "Pride in maternity staff bulletin" was issued 3 August 2015. This was designed to keep staff abreast of the progress being made with the maternity improvement plan and service developments. Minutes from the maternity gold meeting on 21 October 2015 stated "second maternity bulletin a month late." This showed a lack of commitment to the implementation of this staff engagement vehicle.

- A staff event had been planned for 4 November 2015; however this was cancelled and had not been rearranged at the time of our inspection. This was to be open to all as a "pride in maternity" event.

Innovation, improvement and sustainability

- Senior and clinical managers were concerned that the improvements made with the maternity improvement plan were not sustainable as there were no systems for continuous improvement.
- One of the initiatives to aid improvement was to link with the maternity services at Newcastle upon Tyne hospital. However we found only two staff members who had visited their services or had any consultation with them. We were told further joint visits were planned.
- Midwives and managers were enthusiastic to introduce new ways of working and had ideas for change; however due to the shortage of staff the day to day work took precedent and there was a lack of time and no system in place for them to develop the service.
- The specialist gynaecology nurses were improving and expanding the services they offered. Staff had completed training in the use of lasers and the equipment was being moved from theatres to allow these procedures to take place on an outpatient basis.
- The trust had adopted the Saving Babies Lives program as part of the maternity improvement programme,

Services for children and young people

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

Information about the service

At Royal Oldham Hospital the trust has a level 3 neonatal unit that provides the highest level of specialist intensive care for the sickest infants and preterm babies from within Pennine Acute Hospitals area and also accepts referrals for intensive care from out of the Greater Manchester area. The unit provides high dependency and special care for babies who no longer require intensive care. There are 37 cots providing intensive care, high dependency care (HDU), special care and transitional care. The unit has 19 level one beds, nine level two beds and nine level three beds. The neonatal unit operates as part of a regional neonatal managed clinical network to ensure best outcomes for babies.

Most other services for children and young people under 16 are provided from the paediatric ward and in the observation and assessment unit. The ward consists of 27 inpatient beds, two of which are designated HDU bed. The beds are laid out in nine individual cubicles and four four-bedded bays. The ward space has additional beds so provision can increase to 25 beds, 11 cubicles and 2 HDU beds. At the time of our inspection the extra beds were closed.

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

At Royal Oldham Hospital Children's surgery is performed from the paediatric unit. From July 2014 to July 2015, there were 7758 admissions to children and young people services. 7524 of these admissions were emergency admissions, 193 were day case admissions and 41 were elective admissions.

As part of our inspection from 23 February to 26 February, we visited inpatient and outpatient areas, paediatric A&E, paediatric surgery services, the paediatric assessment area and neonatal unit. We spoke with a range of staff providing care and treatment in children and young people's services including: 11 nurses, 2 trainee doctors, one consultant, four health care assistants, one play specialist, one ward clerk a domestic and senior managers.

We talked with seven parents on the ward areas. We observed patient care, talked with carers and reviewed 21 patients' records of personal care and treatment.

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

Services for children and young people

Summary of findings

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

Patient safety was a significant concern because:

- Risks were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate them in the longer term.
- There was a failure to effectively investigate and learn from incidents and complaints. There were unacceptable delays in investigations including those resulting in severe harm.
- There was a lack of accurate record keeping which impacted on the services capability to evidence their assessment and responsiveness to patient risk.
- Patient's privacy and dignity were not always upheld.
- There were few mechanisms for staff engagement and plans to improve this had not taken place.
- We found that the care and treatment delivered did not always reflect current evidence-based guidance, standards and best practice.
- There were gaps in management, supervision and support arrangements for staff. Children received care from insufficient number of staff that did not have refreshed skills or experience that is needed to deliver effective care.
- We found that the needs of the local population were not fully understood when planning this service particularly when considering the number of under two's that would access the children's wards.
- Some people were not able to access services for treatment when they need to.
- There was significant concern regarding how well led the paediatric service was. The delivery of high quality care was not assured by the leadership, governance or culture in place.

However

- On the neonatal unit staff interactions were positive and babies were treated with kindness and compassion.
- Parents felt supported and involved in the planning and decisions regarding their child's healthcare.

Services for children and young people

Are services for children and young people safe?

Inadequate

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

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

- There were unacceptable delays in the investigation of serious incidents. Learning from incidents was not effectively shared resulting in serious incidents with similar causal factors recurring. This meant the service did not evidence that appropriate actions had been taken to ensure patient safety.
- The trust board relied on incident reporting as an assurance mechanism regarding patient safety. However, nursing staff told us that incidents were not always reported and we observed this on our inspection. Senior nursing staff were aware that staff did not report all incidents. The trust board could not safely rely on incident reporting as a patient safety assurance mechanism because all incidents were not reported
- Nurse staffing levels and skills mix in paediatrics did not reflect Royal College of Nursing (RCN) guidance (August 2013). In neonatal the levels and skills did not meet British Association of Perinatal Medicine (BAPM) guidance.
- The number of medical and nursing staff that had completed their essential job related training was very low and this risk was not recorded on any of the trust's risk registers.
- Neonatal records showed that 23.9% of nursing staff had current NLS training at the time of our inspection.
- In paediatrics the observation and assessment unit only had one trained member of staff on shift five times from December 2014-December 2015.
- Hospital trusts have a legal obligation to ensure that electrical equipment that has the potential to cause injury is maintained in a safe condition. During our inspection we found approximately 50% of equipment that did not show evidence of current Portable Appliance Testing(PAT). The trust's electrical equipment maintenance log also showed over 50% of equipment was out of date for its routine maintenance which is a breach of the Electricity at Work Regulations 1989 and the trust's policy.
- Assessments to identify patient's clinical risks had not been completed in line with the trust's policy. Records for the monitoring of children, including neonates, to detect deterioration in their condition were not accurately completed. There was inconsistency in the escalation of children for medical review.
- The intercollegiate document on safeguarding recommends 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be level three trained. At Pennine Acute 72% of paediatric nursing and medical staff had completed level three safeguarding training and 30% of neonatal nursing and medical staff had completed this training.

However;

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

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

Incidents

Serious Incidents

- There was a disparity in data provided from the trust regarding the number of reported Strategic Executive Information System (Steis) serious incidents at Oldham Hospital. Three serious incidents were reported by the Trust between 7 February 2015 - 28 February 2016. However during the inspection it was determined that

during the same period there had actually been five serious incidents. The Trust's system for collating the STEIS information did not collate all serious incidents. We requested the investigation records (root cause analysis) for these five incidents and evidence of lessons that had been learnt. There was one Steis incident in neonatal four Steis incidents in paediatrics.

- Two of these serious incidents had been reported after another hospital escalated their concerns regarding patient care. However we spoke with approximately 27 members of staff and they were all aware of the trusts electronic reporting system Notifications to Steis were delayed by up to two months in two of the five incidents.
- At the time of our inspection two of the the five paediatric incident investigations had been completed. The other three were ongoing, despite them being outside the trust's timeframe for serious incident investigations.
- We reviewed the two available root cause analyses for paediatric cases. There were lengthy delays in the investigations and lessons learnt were not shared in a prompt manner. We found no evidence that immediate actions to mitigate ongoing risks were implemented. Learning from incidents was not shared for several months and when it was initiated it was via a meeting that was only attended by medical staff, despite nursing issues being identified as some of the causal factors.
- When asked, nursing staff at ward level stated they were unaware of the learning from serious incidents. We requested ward meeting minutes and quality and performance meeting meetings. We did not receive the ward meeting minutes.
- Across the trust serious incidents with similar contributory causes had recurred in the period between the first incident and learning/actions being shared preventing actions that would reduce the risk of recurrence.
- During our inspection we discussed preliminary findings of serious incidents that had occurred more recently where the RCA was not available. We were told initial findings identified similar causal reasons to those previously identified in other incidents up to a year earlier. These initial findings had not been shared. For example early warning scores(EWS) completion and escalation issues had been identified as recurring causal factors in paediatric serious untoward incidents previously. To address this the trust had identified that EWS were to be audited from May 2015. One audit was undertaken in May 2015 which highlighted weaknesses in EWS completion and escalation. However, no further action resulted from this audit. No further audits were undertaken from May 2015 up to our inspection.
- At our inspection we found evidence that EWS had been partially completed and not acted upon. Senior staff told us they were aware that there were still issues and further serious untoward incidents had occurred where EWS completion and escalation had been identified as causal factors. This issue was taken up with matron at the time of the inspection
- The children's directorate risk register highlighted 'failure to ensure the ongoing monitoring of SUI [serious untoward incident] recommendations are appropriately incorporated and executed in action plans, could result in failure to learn lessons and to prevent avoidable harm in the future.
- To mitigate this risk the trust stipulated that audits would be undertaken to review recommendations being implemented. We requested a copy of the audit that was scheduled to be undertaken in January 2016. This audit had not been completed at the time of our inspection.

Other incidents – paediatrics

- From December 2014 to December 2015 trust data showed that 136 incidents were reported on the children's ward and observation and assessment area. Most of these incidents (66.9%) were risk assessed as no harm incidents.
- On the paediatric unit we found 63 incidents that had occurred we were informed a backlog of reviewing and investigating incidents had arisen due to a staffing issue. The Matron told us she had put steps in place to address this issue going forward.
- In the paediatric unit we found a culture where staff were used to not reporting incidents. These included staff shortages and safeguarding concerns. During our

inspection we observed three incidents that were not reported. This meant that the trust board could not use incident reporting as an assurance mechanism for patient safety.

- On the paediatric unit nursing staff explained if they were directly involved in an incident, provision of feedback was always not consistent. The nursing staff we spoke with explained they got feedback on incidents involving medications and sometimes for other things, e.g. staffing. All nursing staff told us that the ward meetings mainly discussed medication errors. We requested a copy of the ward meeting minutes but did not receive them.
- The trust's governance report indicated that the risk level within paediatrics was increasing. Senior staff told us that this was probably based on there being an increase in the numbers of incidents being reported within the last quarter. However, senior staff were aware that incident reporting had recently decreased and that staff were not reporting all incidents.
- The paediatric unit had a quarterly morbidity and mortality meeting where relevant cases were discussed. However, there was a lengthy delay before serious cases were presented at these meetings and discussed. This meant there was a risk of incidents recurring before immediate learning from serious untoward incidents had been shared.
- The paediatric nursing staff we spoke with were unaware of morbidity and mortality meetings or any recent outcomes/learning. However, on both units medical staff reported that they were informed about morbidity and these cases.
- Staff told us that they were aware of the duty of candour as a duty to be open and honest to people.
- In the incidents we reviewed, it was clear that duty of candour principles were not correctly followed in relation to serious incidents. In one case we reviewed the trigger for the incidents being investigated was when another hospital reported the incident. RCA's showed no evidence that duty of candour principles had been followed at the time the incidents occurred. However, the trust has assured us the duty of candour was followed after the incidents had been investigated.
- On the paediatric unit the matron had recently introduced weekly meetings between governance leads and ward managers so incidents could be reviewed and appropriate action taken. However, we found 63 incidents that had occurred over a period of 18 months that not been reviewed at the time of our inspection.
- We found that when concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety. This represented a patient safety risk.

Other incidents - neonatal

- On the neonatal unit from December 2014 to December 2015 341 incidents were reported. Most of these incidents (83%) were risk assessed as no harm incidents.
- At the time of our inspection the neonatal unit had 65 open incidents that had not been investigated .
- We asked matrons about this and were informed that on neonatal a backlog had arisen due to staff capacity issues resulting in fortnightly governance meetings not occurring. The neonatal matron had looked at the incidents to identify any that needed immediate action, but the incidents had not been investigated.
- In neonatal we found a culture where staff were encouraged to report incidents and a link nurse reviewed incidents one day per week . However, some medical and nursing staff told us they were not reporting all incidents. Senior managers within the division told us they were aware of this and that they reminded staff to report incidents. However, no further action was taken against staff who did not report these incidents.
- The neonatal unit had a monthly perinatal meeting where cases were discussed and learning resulting from them was shared/confirmed had been actioned. Minutes from the meeting were shared within the division and were a standing item on the divisional quality and performance meeting.

Cleanliness, infection control and hygiene

- In July 2015 the neonatal unit was audited and was found to be 100% compliant with MRSA prevention, 95% compliant with infection control policies, 86% compliant with PPE usage and 86% compliant for hand hygiene.
- In December 2015 an audit was undertaken in neonatal. This showed the unit was 88% compliant with the trust's infection control procedures. However, not all the recommended actions were assigned to people for completion.
- In November 2015 an audit was undertaken in paediatrics. This showed the unit was 80% compliant with the trust's infection control procedures. The trust target for compliance was 85% or more. At the time of our inspection not all the recommended actions were assigned to people for completion and there was no re-audit date listed.
- During our inspection we requested sight of daily cleaning rotas. Cleaning staff explained they did not need to complete documentation to confirm cleaning had been done. The trust's cleaning policy states that cleaning schedules for all cleaning should be available to be inspected. We requested to see cleaning schedules from both the cleaning staff and the nursing staff. Cleaning schedules were not available which was a breach of the trust's policy. However, at the time of our inspection clinical areas appeared to be visibly clean.
- In the paediatric unit's play area there were books/toys for children. The books were not covered. Staff explained they cleaned them by wiping them down with a wipe or detergent spray. When questioned as to what happens if a toy or book was used by an infectious child, nursing staff indicated that the toys and books would be discarded by cleaners. However, other staff told us the equipment was cleaned then returned with the other toys and books. This represents an infection control risk which was escalated at the time of our inspection.
- Staff explained toys were cleaned on a weekly basis. The trust's cleaning policy states that toys should be cleaned on a daily basis. Rotas were not regularly completed and did not evidence weekly cleaning took place. We escalated this risk to the Matron.
- Some babies requiring treatment for jaundice who were admitted to the paediatric unit for phototherapy rather than the postnatal ward. This represented an infection risk to babies and is not in accordance with best practice.
- We reviewed the cleaning audits provided by the trust's cleaning contractor. These showed good compliance scores for all units (over 91%).
- Hand gel was readily available on entry to each clinical area and visitors were reminded to use this by staff.
- Staff were observed complying with the trust's policy on being 'bare below the elbows'.
- On the neonatal unit, fresh and frozen milk was stored in tamper proof containers.

Environment and equipment

- On the paediatric and neonatal units door entry systems were controlled with a swipe card access and had video entry systems. Swipe cards were used to exit the paediatric unit. This represented good practice. However, on the neonatal unit there was a push button located at the ward clerk's desk area. On our inspection parents and staff told us that parents let themselves out of the unit. Parents confirmed from time to time they let other people onto the ward. We immediately escalated this risk to the neonatal matron and noted that this had been addressed by our unannounced inspection.
- On the paediatric unit fire safety equipment was located on freestanding stands on the floor. We found that the stand was not secured and could easily fall over and considered it to be a risk to young children. We escalated this issue to the ward manager and fire safety officer. They completed a risk assessment the following day. The risk assessment did not identify all the risks associated with the location of the equipment particularly as the extinguisher stand were on a paediatric ward e.g. the risk of an extinguisher falling on a child.
- During our inspection, we found equipment that did not have up to date maintenance review stickers in place. PAT testing was up to date on approximately 50% of the equipment.
- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause

injury is maintained in a safe condition. We reviewed an equipment maintenance assurance log. On the neonatal unit this log showed that 56% of low risk items, were out of date for their routine maintenance. 77% of medium risk items, were out of date for their routine maintenance. 55% of high-risk items were out of date for their routine maintenance. This included high-risk items including ventilators and infant resuscitaires.

- On the paediatric unit the maintenance log showed that 40% of low risk items were out of date for their routine maintenance. 83% of medium risk items were out of date for their routine maintenance. 74%high-risk items were out of date for their routine maintenance. This meant the trust had no assurance that those items, which included high-risk items such as resuscitaires and ventilators, were adequately maintained and working correctly. From December 2014 – December 2015 there was one incident reported that occurred as a result of equipment failure.
- On the paediatric unit, there was a set of scales that were in use. These scales did not have a battery cover over the battery. The battery was taped in place. This represented a patient and staff safety risk. We asked senior nursing staff to remove the equipment from use immediately.
- Resuscitation trolleys were not tagged on the paediatric ward therefore staff had no assurance the contents were as checked.
- On the paediatric ward two of the resuscitation trolleys that were in use did not have intraosseous gun handles and there were also no cooks needles. These items were listed as present in the contents checklist and had been checked and noted as present that morning.
- We asked the shift leader to verify our findings. The staff member was unable to locate the intraosseous needle (which was in the trolley). After prompting from a colleague, the staff member located the needle then told us that there was only an intraosseous handle in the HDU, which was approximately 60 metres from either of the other two trolleys. We asked what would happen if a child needed intraosseous access and the shift leader advised us that the patient would need to be wheeled round to the HDU. Staff confirmed that a patient had been taken to HDU once in the three months before our inspection. We escalated our concerns as an immediate patient safety risk. This had been addressed by our unannounced inspection.
- On the paediatric unit, the equipment in the store was not charged. In October 2015 there was an incident where there was a delay in a HDU patient being able to use equipment as it had not been charged. The delay was extended because the room was poorly organised. At the time of our inspection the equipment was difficult to see and find as the room was cluttered and disorganised. Our findings evidenced that the trust had not learnt from this incident and embedded learning to prevent a recurrence of this situation.
- On the paediatric unit the sharps bin lids were not closed using the temporary closure mechanisms. This issue had previously been identified as an infection control concern during the infection control audit in November 2015.We told the trust about this. However this was this was ongoing at our unannounced inspection. We again escalated this to the Matron.
- The teenagers' room had extremely limited facilities and activities for teenagers. There was a range of paper books, which represented an infection control risk.

Medicines

- Drugs requiring storage below certain temperatures were stored in fridges. Whilst checks were in place to monitor fridge temperatures, in HDU on three dates the checks were not recorded.
- The neonatal unit staff attended a bi-monthly Safe Administration of Medicines group (SAMs) where all staff were invited to discuss incidents regarding medication.
- An antimicrobial audit undertaken in July 2015 indicated that both the paediatric and neonatal unit were 100% compliant with quality antimicrobial prescribing.
- The service had a designated pharmacist.
- We checked the drugs audits on the paediatric and neonatal units and they were all fully completed confirming that all drugs were in date.

- On the neonatal unit the resuscitation trolleys were fully equipped and regularly checked. However, there were intraosseous needles and cooks needles without expiry dates in the trolley. These items were also not included on the checklist of contents.
- Children were weighed and this was documented within their medical records.
- The trust had electronic prescribing in paediatrics. This system highlighted prescribers to patient's allergies and drugs they may be sensitive too. Patient's weights were also added to the electronic prescribing system. The system then calculated the required dosage of specific medications that a patient needed. On the neonatal unit, prescribing charts were paper-based and contained within medical records.
- Staff told us children wore red wristbands when they had an allergy and that the allergy would be documented in the medical records.

Records

- During our announced inspection we reviewed eight sets of records on the paediatric unit. In all eight records, not all entries were fully legible; not all entries had dates and/or times recorded and EWS (early warning scores) were either partially completed or not completed. This breached the trust's EWS policy and represented a patient safety risk.
- Paediatric nursing records were difficult to navigate. This meant that finding relevant information took extra time.
- In the patient records we reviewed, patient information data was not on all pages and growth charts were not included. When observation charts were partially completed, the actual observations were unclear. However, pain scores were completed and consent forms that were required were appropriately completed.
- During our unannounced inspection we reviewed five sets of paediatric records. In one set of paediatric notes we reviewed the patient was scoring amber but a doctor had not been requested to review the patient due to them looking well. This was not in accordance with the Manchews guidance or the trust's policy. In a separate set of paediatric records, a patient had scored amber on the EWS system indicating they needed a medical review. The notes did not evidence that a doctor had been asked to review the patient in the nine hours the patient had continued to score amber.
- In a further set of records, the patient had been admitted almost 24 hours. There were loose papers filed in the records folder but nothing was completed. There was no admission record and no record that the patient had been seen by medical staff. Facing the Future Standards recommend a patient is seen for a medical review within four hours of their admission. In a fourth set of records we reviewed the staff were questioning whether a patient had a non-accidental injury. It was recorded that a decision would be made on the day of our unannounced inspection. By 20:00 no decision was recorded for that patient.
- In four sets of records there was no documented evidence of discussions with the family or documented consent. We escalated these issues to the senior nurse
- We reviewed eight sets of neonatal notes. In six sets of notes, the growth charts were not completed. In all sets of notes the entries were not consistently completed (signature/ date and designation of the person completing them).
- Of all the notes we reviewed, two had a completed patient risk assessment. In the other six, none had a fully completed patient risk assessment.
- Records were stored securely in locked cabinets.

Safeguarding

- The trust set a target that 60% of staff working with children and young people had to have level three safeguarding training. In the children and young people's service at Royal Oldham Hospital the trust advised us that 56% of nursing staff and 100% of medical staff in paediatrics had completed this training. In neonatal28% of neonatal nursing staff and 18% of medical staff had completed this training. The majority of these figures were below the trust's own target.
- The trust's own target is not in accordance with the national guidance from the intercollegiate document 'Safeguarding children and young people: roles and competences for health care staff' which states that 'all clinical staff working with children, young people and/or their parents/carers and who could potentially

contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns staff should be level three trained.'

- We escalated these issues with the trust as these issues were not recorded as a risk on the risk register.
- Staff we spoke with were aware of safeguarding procedures and who to report incidents too.
- On the children's unit there was not a designated teenagers' bay. This meant that older children/ teenagers and younger children shared the same bays. We asked senior nurses about this. They informed us that they risk assessed the areas where children were admitted on a case-by-case basis dependent on bed availability. Senior staff advised us they did not document their risk assessments.
- We were informed that CAMHS children were not admitted to cubicles because of safety risks and they were nursed in bays.
- The trust had a current female genital mutilation policy.
- At induction all staff are given a PREVENT leaflet to make them aware of their responsibilities regarding safeguarding.

Mandatory training

- At the time of our inspection, none of the paediatric nurses had APLS training. Service leaders were unclear how many staff were up to date with their mandatory training. We requested this information from the trust. The trust informed us that 9/38 (23.7%) nursing staff had current PILS certification on paediatrics and that 23.9% nursing staff had current NLS certification on neonates.
- Medical staffing levels met quality standard IP-203 of the Paediatric Intensive Care Society Quality Standards for the Care of Critically Ill Children.
- The trust target for staff being up to date with their essential job related training is 94%. We were provided with conflicting data during our inspection regarding training and the number of staff that had completed it. We requested specific mandatory training figures for medical and nursing staff at the time of our inspection.
- The subsequent data provided by the trust showed that in paediatrics at Oldham, 56% of medical staff were up to date with their essential job related training. 44% of nursing staff were up to date with their essential job related training. 57% of staff who provided additional clinical services were up to date with their training. 100% of administration staff were up to date with their training. We escalated this to the trust.
- In neonatal at Oldham 75% of nursing staff were up to date with their mandatory training. 63% of staff who provided additional clinical services were up to date with their training. 100% of administration staff were up to date with their mandatory training. 73% of medical staff were up to date with their essential job related training. Most of these figures fell below the trust's target of 94%. We escalated this to the trust.
- On the neonatal unit we reviewed the number of nurses who were qualified in speciality. We reviewed staff rotas from 10 January 2016 to 10 February 2016. This showed 91% of staff were qualified in speciality which is above the national standard.

Assessing and responding to patient risk

- The paediatric unit used MANCHEWS as their early warning score system (EWS). In all the medical notes we reviewed we found that EWS records had not been fully completed. Following an earlier serious untoward incident, failure to complete and escalate early warning scores had been deemed a causal factor in this incident. The recommendation from this review was that audits were undertaken to assess compliance with the EWS policy.
- The trust audited EWS completion in May 2015. This showed that only 34% of the records they reviewed had EWS fully completed on admission.
- We requested more recent audit evidence and an action plan. The trust advised us that no further audits had taken place.
- Across the trust four serious incidents over a year outline failure to respond to escalating EWS as a causal factor. We were not assured that the trust had given sufficient priority to addressing this risk.
- In the Manchews EWS (an early warning score system), observations are plotted onto a chart. In organisations demonstrating best practice the chart is colour coded to indicate when staff members need to take different management actions, e.g. increased observations. The

EWS data was on plain white sheets, which did not make the colour system clear. In all active patient records there were no Manchews scoring charts as a reference guide. It is good practice for this reference guide to be available to staff so they are clear on the actions expected from them depending on the patient's current observations.

- Nursing staff on the paediatric unit did not have APLS training. At the time of our inspection 23.7% nursing staff had current PILS certification. In the month prior to our inspection 76% of staff actually working on the ward had current basic paediatric life support training. BAPM guidance states that all practitioners working with neonates should have NLS certification. Records showed that 23.9% of neonatal staff had current NLS training. We escalated these issues to the trust as immediate patient safety risks.
- In paediatrics child and adolescent mental health services (CAMHS) liaison service were provided by Manchester Mental Health Service. They provided in-reach services to the Emergency Department and Paediatric Wards to assess children. Children requiring CAMHS were admitted directly to the ward and were seen by the CAMHS team. Children remained an inpatient until a specialist bed became available. Paediatric referrals for mental health reasons were admitted to the ward for either paediatric physician management of acute medical conditions or as a place of safety to await CAMHS assessment. However, the ward had no Registered Mental Health Nurses.
- When a CAMHS patient required 1:1 nursing the trust used an agency staff member to facilitate this provision.
- Following anaesthesia designated staff managed children in the recovery area within theatre.
- On the neonatal unit EWS were not used. The trust were developing a deteriorating neonate policy at the time of our inspection but no implementation date had been set.

Nursing staffing

Paediatrics

- We requested evidence from the trust to assess their compliance with Royal College of Nursing (RCN) standards (August 2013) in accordance with best practice. This was to assess safe staffing numbers and skill mix in paediatrics.
- To assess whether a paediatric unit has safe staffing levels, it is essential to know the number of children and their acuity along with the skills mix of staff.
- The trust was unable to identify the number of children in HDU for the month (10 January 2016 – 9 February 2016) prior to the inspection.
- The trust was unable to use its data to tell us how many children were on the paediatric ward for each shift.
- The trust did not routinely use an acuity tool, as recommended by RCN guidance, at the time of our inspection. However, in December 2015 the trust trialled an acuity tool for one week (19 shifts). At the time of our inspection no plans were in place to introduce an acuity tool.
- RCN guidance for safer staffing recommends a staff ratio of 1:3 for children under two years of age and 1:4 for children above 2 years of age. For children requiring High Dependency Unit (HDU) care the ratio 1:2 is recommended.
- We found that 0 out of 19 shifts (0%) were staffed in accordance with RCN guidance in terms of the recommended staff: patient ratio. On average each shift was understaffed by three registered nurses.
- No staffing incidents were reported whilst the acuity tool was being used. This meant that shift co-ordinators either failed to recognise that the ward was short staffed or failed to report an incident which was their responsibility.
- On the paediatric ward the number of beds on the ward could increase above 27 if it was risk assessed as safe to do so. Staff told us that the risk assessments that were undertaken were based on the number of staff and patient acuity. These risk assessments were not documented. We reviewed the acuity tool and in 31.6% of shifts the trust had more than 27 children on the paediatric ward. There was no evident increase in staff numbers to reflect that staff: patient ratios had been considered.

Services for children and young people

- We reviewed the planned vs actual staffing figures on the ward. In 16.1%% of shifts nurse staffing was at least one registered nurse short. Planned staffing did not appear to take into consideration that just over 50% of the children that attended the ward were under two years old.
- We reviewed incident logs. On the weekend prior to our inspection there were three trained members of staff on duty with 20 children to manage. A GP admission came to the ward with a Glasgow Coma Score (GCS) of 3. Two staff had to stabilise the patient. The nurse practitioner was bleeped but no extra staff went to the ward to help. This left one nurse caring for 20 children.
- On the paediatric unit from December 2014 – December 2015 28 incidents were reported regarding staffing. 24 of these incidents were risk assessed as no patient harm cases, 3 were assessed as low harm and one was assessed as moderate harm. Included in the incident reports staff stated that the ward did not feel safe, the impact on patient care and that staff were not able to take breaks and stayed past the end of their shifts.
- Royal College of Nursing (RCN) standards (August 2013) recommend that there is a senior children's nurse available for advice at all times throughout the 24-hour period. The trust did not have this provision in place on 47 of 93 shifts (50.5%) over a month.
- Royal College of Nursing (RCN) standards (August 2013) recommends that a nursing staff member has APLS/ EPLS training at all time throughout the 24 hr period. The trust did not have any APLS/EPLS trained nursing staff members in paediatrics. They informed us that 9/38 (23.7%) nurses had current PILS certification in paediatrics.
- To gain assurance that the paediatric ward had nursing staff with some level of current life support training, we reviewed the rotas for the month (10 January 2016 – 9 February 2016) prior to our inspection. This showed that 76% of nursing staff on shift had basic paediatric life support training.
- Over the six months prior to our inspection the average sickness rate for paediatric nursing staff was 6.8%. This was above the trust's target of 5.0%.
- Over the six months prior to our inspection the average sickness rate for non-registered nursing staff was 15.8%. This was above the trust's target of 5%.
- On the observation and assessment unit five staffing incidents were documented stating that only one trained nurse was on the unit. This is not in accordance with best practice and is against RCN guidance which recommends there should always be two trained staff on a unit.
- Nursing staff told us that regularly they did not take all their breaks.
- Failure to achieve safe staffing levels across the division has been recorded on the risk register since 28 November 2014. Controls were outlined that included reassessment of clinical workload in relation to nurse/ patient ratio and the booking of bank staff to cover shortfalls.
- Insofar as reassessment is concerned, the escalation policy the trust used did not follow the RCN guidance for the ratio of staff to children. We escalated this and this was updated prior to our unannounced inspection.
- Nursing staff told us that prior to our inspection the ward was never closed to all admissions, only to A&E admissions (approximately 405 children per month). This was in accordance with the trust's escalation policy. The Royal Oldham Hospital admits approximately 287 children per month as GP admissions. This meant that although some attempt at risk reduction had taken place, senior staff did not adequately mitigate the risk presented by the staffing deficit as the ward didn't close.
- The trust could not tell us the number of times beds had been reduced to address staff shortages as their bed management system did not record this information.
- Nursing leads told us booking of nursing staff had proved more problematic recently as the trust had stopped using a local agency due to costs. Following escalation of our concerns regarding staffing, the trust started reusing the local agency.
- We saw evidence of clinic cancellation because of the staffing situation, evidencing impact on patient care.

- Medical staff expressed concern regarding nurse staffing, particular at night. They explained that they could not get admissions into the ward. Medical staff reported having to ring around different units to find beds, which was reported to be time consuming.
- There was reliance on bank and locum staff within the paediatric service for medical and nursing staff. Agency staff were reported to have received appropriate paediatric training and staff told us that agency staff were given computer access during their shifts.
- High dependency children are nursed on the wards. No specific training is provided for nursing staff which is against Paediatric Intensive Care Standards 2010.
- In paediatrics there were ward clerks from Monday to Friday from 9:00 to 17:00 Monday-Friday. On three of these evenings ward clerks were available to 20:00. Outside these times nursing staff did their own administration and managed the door entry systems.
- On paediatrics volunteers were used to monitor entry to the ward and meet and greet people.
- We observed a paediatric nursing handover. Contradictory information was provided regarding the number of children that were due to be admitted from A&E. Children were allocated based on their location on the ward, rather than based on acuity.

Neonatal

- The neonatal unit used guidance from the British Association of Perinatal Medicine (BAPM) with regard to staffing levels. They planned, using BAPM standards, for 85% occupancy.
- We reviewed neonatal staffing in line with BAPM (British Association of Perinatal Medicine) guidance over the course of a month. In 17/96 shifts (25.8%) nurse staffing did not comply with BAPM guidance for the nurse: patient ratio. On average in each of these shifts the unit was understaffed by at least one registered nurse. When we reviewed the planned vs actual staffing information, this showed in 80/96 (83.3%) of shifts the unit was understaffed by on average 2.2 nurses.
- On the neonatal unit from December 2014 – December 2015 three incidents were reported regarding staffing. Two of these incidents were risk assessed as no harm incidents and the other was a 'near miss' incident. The incidents all suggested care was compromised as a result of lack of staff. In the near miss incident it was reported that staff were managing intensive care babies requiring 1:1 ratio on a 1:3 basis. It is recorded staff were unable to take their breaks.
- 23.9% nurses had current NLS certification on neonates. We raised these issues with the trust at the time of the inspection.
- Over the six months prior to our inspection the average sickness rate for neonatal nursing staff was 6.5%. This was above the trust's target of 4.0%.
- In neonatal there were ward clerks from 8:00am – 7:00pm from Monday to Thursday and on Fridays from 8:00 am to 4:00pm.

Medical staffing

- The percentage of consultants working in paediatrics within the trust was 32% which was less than the England average of 35%. The percentage of registrars was 50% which was marginally less than the England average of 51%. 12% of the medical staff were junior doctors, which was higher than the England average of 7%.
- The trust had seven paediatric consultants in post and three locum consultants. Their rotas were reported to be consistently covered and were compliant with the European working time directive (EWTD).
- The consultants took part in a 'hot week' rota system where they would be first on call during that week. Consultants were present on the children's ward from 9am to 5pm. On call paediatric consultant cover was also available from 5pm to 9am Monday to Friday and at weekends. The paediatric ward had registrar and junior doctor cover 24 hours a day on site as they also covered A&E
- Facing the Future Standards recommend there should be consultant presence on the ward at self-defined peak times. Hospital staff told us that their peak times were between 4pm and 9pm. The hospital had consultants' scheduled to be on site up until 5pm. We raised this issue with the trust. They confirmed that consultant presence during peak times was not in place. The trust

advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.

- Facing the Future Standards recommend that every child who presents with an acute medical problem is seen by a consultant, or equivalent, within 24 hours. In one paediatric serious incident investigation we reviewed this had not occurred and was deemed a causal factor in the delay of diagnosis. The trust did not monitor this standard at the time of our inspection.
- On the neonatal unit, neonatal consultants cover the rota. The consultants took part in a 'hot week' rota when they would be present on the neonatal unit 8:30am to 6pm from Monday to Friday. At weekends the 'hot week' consultant was on site from 8:30am – 2:30pm. On call consultant cover was also available 4pm to 8:30am from Monday to Friday and at weekends from 2:30pm – 8:30am. The neonatal unit had registrar cover on long days from 8:30am – 21:30pm and standard days from 8:30am - 4:30pm. Junior doctors covered the unit on long nights 8:30pm - 9:30am and nights from 8:30pm - 9:30am. Further ward cover was provided by junior doctors at weekend from the postnatal ward between 8:30am - 8:30pm.
- On neonatal on most days there were two Tier 2 doctors (registrars) during the day and two Tier 1 staff members (junior doctors or Advanced Neonatal Nurse Practitioners). There were also two consultants one attending the Intensive Care /High Dependency areas and one responsible for Special Care.
- Medical staff sickness levels on neonates and paediatrics were below the trust's target of 5% for the six months prior to the inspection.

Major incident awareness and training

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

Are services for children and young people effective?

Requires improvement

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

- We found that care and treatment did not always reflect current evidence-based guidance, standards and best practice. On the paediatric unit we found Partners in Paediatrics (PiP) guidance had recently been put in place, but this had not been adapted to include trust contact numbers to make the guidance work locally particularly for junior or locum staff members. 8/64 policies and procedures were not up to date.
- Children received care from staff who did not have the skills that are needed to deliver effective care. There were very low numbers of nursing staff who had current PILS certification, no nursing staff who had APLS training and 23.9% staff who had current NLS certification.
- Trust targets for essential role specific training were not achieved. This meant staff did not have their skills refreshed.
- Whilst staff felt supported in additional training and development, basic training needs including safeguarding were not appropriately addressed. There were gaps in management, supervision and support arrangements for staff and appraisal figures were very low and below the trust's target of 85%.
- Consent for non-surgical procedures and discussions with families were not documented in the patient notes we reviewed.

However;

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

Evidence-based care and treatment

- Policies and procedures were provided on the trust's intranet. The trust had a flagging system to indicate when policies were coming up for revision and when

they were out of date. However, at the time of our inspection eight policies were out of date despite these being appropriately flagged. These included policies for pain, diabetes and child abduction.

- At the time of our inspection the paediatric service had recently introduced Partners in Paediatrics (PiP) guidance. However, this had not been localised to the trust. This meant that whilst there was guidance on what to do, how to do this within the trust and who to contact within the trust was not available. As a result of this the guidance did not work as effecitively as it could for junior medical staff and locum staff because they had to look elsewhere for this information. We asked senior staff about this and were told that the service was in the process of developing further guidance. A definitive deadline for when they would be available was not provided.
- A review of policies and procedures was scheduled, as part of the paediatric improvement plan, to be undertaken at the end of February 2016. On our unannounced inspection in March, the clinical lead told us this review had not been undertaken and seven out of eight policies remained out of date.
- NICE guidance requires transition pathways to be in place. With the exception of diabetes, and neuro-disability, transition arrangements were not in place within paediatrics. However, the trust did recognise that it required significant improvement in this area and had recorded on the paediatric improvement plan that on 29 February 2016 they would begin to address this need going forwards.
- The paediatric service did not offer other transition pathways at the time of our inspection. However, the trust did recognise that it required significant improvement in this area and had an action plan in place to help them begin to address this need going forwards.
- The neonatal unit had Bliss Baby Friendly accreditation.
- Whilst the median glycaemic level is similar to that of England (Trust 74, England 72mmol/mol), NICE define excellent diabetes control as HbA1c levels less than 58 mmol/mol as this indicates good glycaemic levels. The higher the HbA1c levels the greater the risk of complications. 16% of the Trust's children were reported as having a HbA1c under 58 mmol/mol which is a lower proportion of children with well managed diabetes than the England average of 19%.

Pain relief

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

Equipment

- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. We reviewed an equipment maintenance assurance log.
- On the neonatal unit this log shows that of 109 low risk items, 61 were out of date for their routine maintenance. Out of 351 medium risk items, 271 were out of date for their routine maintenance. Out of 351 high-risk items, 154 were out of date for their routine maintenance. This included high-risk items including ventilators and infant resuscitaires.
- On the paediatric unit this log shows that of 95 low risk items, 38 were out of date for their routine maintenance. Out of 421 medium risk items, 350 were out of date for their routine maintenance. Out of 47 high-risk items, 13 were out of date for their routine maintenance.
- This meant the trust board had no assurance that those items, which included high risk items such as resuscitaires and ventilators, were adequately maintained and working correctly. However, from December 2014 – December 2015 there was one incident reported that occurred as a result of equipment failure.

Nutrition and hydration

- On the paediatric unit children were given a choice of meals from the serving trolley. Nursing staff were able to order meals from the kitchen, before 6pm, to cater for different dietary requirements.
- Snacks and drinks were available on request.

- The service had dietic input from a dietician.
- Breast pumps were loaned to women to encourage feeding of breast milk.

Patient outcomes

- The trust's multiple (two or more) readmission rates are higher than the England average for asthma, diabetes and epilepsy for 1-17 year olds. The England average for asthma is 16.8%, for diabetes is 13.6% and for epilepsy is 27.8%. The trust's average for asthma is 19.1%, for diabetes is 17.3% and for epilepsy is 33.8%.
- In the National Neonatal Audit Programmes (NNAP) 2014 audit, the neonatal unit at Oldham scored below the national average in 3/5 questions. NNAP standards include that 98%-100% of babies (that are born at 28+6 weeks gestation or older) should have their temperature taken within an hour of birth. At Oldham 100% of babies had this done within the time frame. 87% of mothers also received a dose of antenatal steroids which was above the national standard.
- A NNAP standard is that 100% of eligible babies should receive ROP screening within the timeframe provided. At Oldham 98% of babies received this screening in the correct timeframe.
- NNAP benchmarks the percentage of babies that receive any of their mother's milk at the time of discharge at 58%. At Oldham 52% of babies received their mother's milk at the time of discharge.
- NNAP outline that 100% of parents should be consulted by a senior member of the neonatal team within 24 hours of admission and that this consultation should be documented. At Oldham they achieved this in 84% of admissions. The unit explained this had improved since 2014 to 86.5%. In a further 8% of cases the discussions were documented outside 24 hours but occurred within that period.

Competent staff

- The service had two escalation beds which were located in a separate room which was labelled as a high dependency unit and referred to as this by all staff, incident reports and records. These beds were managed as HDU beds and were used for treatment of children who are described by the Paediatric Intensive Care Standards as receiving level one care. The trust told us that specific HDU training was not provided for paediatric staff. This is against Paediatric Intensive Care Standards which state that "Children needing high dependency care should be cared for by a children's nurse with paediatric resuscitation training and competences in providing high dependency care."
- Staff we spoke with confirmed that they were not up to date with their appraisals. At Oldham Hospital 79% of paediatric staff were up to date with their appraisals. A number of staff on the paediatric unit had been identified as not following trust policies and actions identified from clinical audit. However these capability issues were not being addressed in a timely way because managers had failed to document supervision where shortfalls in practice had been identified.
- At Oldham 68% of neonatal staff were up to date with their appraisals.
- The trust has a target that 94% of staff should have completed their essential job related training. The trust has provided us with conflicting data regarding this.
- In paediatrics at Oldham, 56% of medical staff were up to date with their essential job related training. 44% of nursing staff were up to date with their essential job related training. 57% of staff who provided additional clinical services were up to date with their training. 100% of administration staff were up to date with their training.
- In neonatal at Oldham 75% of nursing staff were up to date with their mandatory training. 63% of staff who provided additional clinical services were up to date with their training. 100% of administration staff were up to date with their mandatory training.
- We escalated the above issues to the trust as the percentage of trained staff was below the trust's own targets.
- Staff on the neonatal unit were rotated to the trust's level two unit at North Manchester General Hospital to enable staff within the level two unit to broaden their skills.
- The paediatric team had one paediatric practice educator who worked across all four sites. They supported induction for new staff members and training needs that arose within the team.
- In the neonatal unit there was an education team. This team worked to provide for education needs and also completed clinical practice. For example because neonatal staff were regularly called to support staffing on the paediatric unit, the neonatal education team liaised with the paediatric practice educator to arrange for staff members' training needs to be addressed.

Services for children and young people

Multidisciplinary working

- On the neonatal unit a physiotherapist attended weekly.
- Paediatrics and neonates had input from speech and language therapists four times a week.
- Patient records included good multidisciplinary involvement.
- The paediatric unit and neonatal unit had designated pharmacists.
- Physiotherapy provided a five-day service accepting referrals from acute consultants in paediatrics, orthopaedics and A&E. During the four months prior to our inspection the maximum wait for non-urgent referrals was 6 weeks. At the time of our inspection urgent referrals were offered appointments within 7 working days.
- There was a full-time speech and language therapist in post offering support to the paediatric and neonatal units five days per week.
- The trust had play specialists available Monday-Friday from 9am – 5pm. These staff worked at Royal Oldham Hospital and in outpatients.

Seven-day services

- Consultant on-call cover was provided out of hours.
- Seven day services were provided on the paediatric unit, on the observation and assessment unit and on the neonatal unit. The paediatric and neonatal wards had access to diagnostic imaging for emergencies seven days a week. However, outpatient appointments were only available from Monday to Friday.

Access to information

- Policies and procedures were kept on the trust's intranet and staff were familiar how to access them.
- When children were discharged from hospital a discharge letter was either sent by email or in the post to their GP. A discharge summary was also provided to parents.
- GPs could access telephone advice from a paediatrician within the observation and assessment unit.

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Consent

- Staff were aware of appropriate procedures in obtaining consent and described how Gillick competence was assessed to establish if children had the maturity to make their own decisions and understand the implications of treatment. However, we found this was not documented in medical records.
- We observed consent forms in place where adults and parents could co-sign to consent to procedures.

Are services for children and young people caring?

Requires improvement

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

- Paediatric staff told us frequently there were times when they had to focus on the task they were undertaking rather than treating people as individuals to ensure that essential jobs were done e.g. provision of medications. Parents confirmed and we observed that they provided cares for their children because nursing staff were unavailable.
- During our unannounced inspection staff told us that their ability to spend time with children and provide support had improved significantly and we observed staff engaging with children and their parents kindly.
- Friends and family test results were poor, but parents and children on the ward at the time of our inspection did not support the tests findings.
- Staff did not always see people's privacy and dignity as a priority.
- Staff focused on the task rather than treating people as individuals.

However;

- On the neonatal unit staff interactions were positive and babies were treated with kindness and compassion. Parents were involved with decisions and kept informed about their baby's care.
- We did not have concerns regarding the caring approach of staff in the neonatal unit.
- Parents and carers were, in the main, positive about the care and treatment provided. They felt supported and involved in the planning and decisions regarding their child's healthcare.
- People's social needs were understood.

Services for children and young people

Compassionate care

- In the 2014 CQC Children's survey the trust scored about the same as other trusts in 19 of the applicable questions. In five questions the trust scored worse that other trusts. These questions related to staff members availability; staff playing with children; staff caring for children listening to parents and carers; staff being friendly with children and parents being told different things by different people. The trust scored better than other trusts for the explanations provided to parents before procedures or operations.
- We discussed the findings of the CQC Children's survey with different staff members and also questioned parents and children regarding their experience.
- Parents we interviewed described staff as being approachable, chatty and friendly. However, they did comment that staff were always busy.
- We observed a number of interactions to be rushed and task based. We also observed children being left alone in cubicles that had not been made child friendly.
- All staff that we spoke with explained that they tried to provide compassionate care to children, but frequent low staffing numbers meant it was challenging and that basic care needs were their primary focus. Staff acknowledged that there were times when they could not provide the explanations they wanted.
- At Oldham Hospital one child with learning disabilities was being undressed and bathed in view of the nursing station. Whilst the nursing staff member was caring and compassionate with the patient, consideration had not been given to their dignity and respect.
- We explored play provision and found that when the friends and family survey was undertaken there were staffing shortages within the play therapy team. At the time of our inspection the team was fully staffed. Parents and children we spoke with confirmed that children were offered a range of play activities.
- The service were trialling a text messaging feedback service in order to improve the level of response they received regarding the services they provided. At the time of our inspection staff were investigating ways to increase uptake of this.
- The service did not have an inpatient survey. They had recently introduced an open and honest board where children/carers could leave their feedback.
- The NHS Friends and Family Test was not undertaken on the neonatal unit. However, comment cards were available for provision of feedback.
- On the neonatal unit we observed patient interactions. Staff introduced themselves to parents prior to consultation. Doctors and nurses communicated with babies and their parents when interacting with them. Doctors and nurses provided explanations to parents so that parents could understand procedures. Babies names were used in interactions, parents were given opportunities to ask questions and staff were gentle and kind when handling babies and giving them feeds.
- Bereavement support was provided by the neonatal service.

Understanding and involvement of children and those close to them

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

Emotional support

- During our inspection we observed that children were frequently left in the care of nursing staff by their parents and carers in an unfriendly environment.
- Children admitted requiring CAMHS were supported by ward staff and agency workers if they required 1:1 support. However, there was no Registered Mental Health Nurse on the ward.
- Play specialists were available from Monday to Friday from 9:00am – 5:00pm. They supported children undergoing procedures on the ward. Outside these times the play room was locked.
- Play specialists did preparation work with children requiring surgery and accompanied all children and parents to theatre.
- In response to the children's survey, staff at all levels told us that to improve caring provision empathy training was now provided as part of induction and mandatory training.

Services for children and young people

Are services for children and young people responsive?

Requires improvement

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

- We found that the needs of the local population were not fully understood when planning this service particularly when considering the number of under two's that accessed the children's wards.
- Planned staffing did not appear to take into consideration that just over 50% of the children that attended the ward were under two years old.
- Some people were not able to access services for treatment when they needed to. Over one month 8 children were transferred to other hospitals to receive their care. Over three months 98 clinics were cancelled.
- There were gaps in transition to other services. Transition pathways were only in place for diabetes and neuro-disabilities for example there were no transition pathways for asthma and epilepsy. This is not in accordance with NICE guidance or best practice.

Service planning and delivery to meet the needs of local people

- The paediatric ward corridors and nursing stations were child friendly. The main nursing station was designed to look like a tractor. Games consoles and games were available as well as DVDs. We observed robot television units which incorporated a DVD player and a games system.
- Children were accommodated in mixed age/sex bays which meant that teenagers were accommodated next to infants. Cubicles lacked child friendly decoration.
- Planned staffing did not take into account that just over 50% of the children that attended the ward were under two years old. Consideration had not been given to the demographic and that parents did not routinely stay for long periods with their babies/children.
- The service did not operate wifi on the ward. The service told us the issue had been risk assessed as a safeguarding issue. We requested the risk assessment but did not receive it.
- Parents were encouraged to stay with their child on the paediatric ward. There were camp beds on the paediatric unit. A parents' room had recently been introduced to enable parents to make hot drinks for themselves. On neonatal there were four en-suite transitional care bedrooms.
- There were designated parents rooms with suitable facilities on both units. The hospital provided access to hot and cold food.
- Meals were offered to breast feedings mothers on the paediatric and neonatal unit.
- GPs could seek telephone advice from paediatricians on the observation and assessment unit.

Access and flow

- Admissions to the paediatric ward were through A&E, GP referrals and the observation and assessment unit. From August 2015 – 10 February 2016, 115 children under 16 were transferred to other hospitals to receive care. There was 1 transfer for 16-17 years olds during this period.
- The service achieved the national referral to treatment target between April and November 2015 within the paediatric specialities. However, from December 2015 – February 2016, 98 clinics were cancelled.
- NICE guidance requires transition pathways to be in place. With the exception of diabetes, and neuro-disability, transition arrangements were not in place within paediatrics. However, the trust did recognise that it required significant improvement in this area and had recorded on the paediatric improvement plan that on 29 February 2016 they would begin to address this need going forwards.
- The paediatric service did not offer other transition pathways at the time of our inspection. However, the trust did recognise that it required significant improvement in this area and had an action plan in place to help them begin to address this need going forwards.
- On the paediatric unit beds were not permitted to be closed to GP admissions. This meant that even when the escalation policy had been followed, the ward would not be fully closed to admissions.
- Community nurses attended the paediatric ward each day to help discharge children who could be cared for in the community.
- The trust had a 'Gateway' triage system in place for most GP referrals (excluding cancer referrals). This had been

set up by the local commissioning groups. GPs referred children directly to the service, where a team assessed referrals and signposted children to the correct services within the hospital or provided them with advice.
- The service had a guideline for admission of children aged 16 to 18 years to adult wards. This clearly set out the procedures and expectations for staff for these admissions.
- Open visiting was available to parents with children on the paediatric and neonatal units.

Meeting people's individual needs

- Parents explained that they were given information leaflets advising them how to care for their child's particular medical condition. During our inspection we observed this taking place.
- A play service was provided from 9:00 – 17:00 Monday-Friday. The ward had a play room, a teenager's room and a sensory room. Each morning that play leads set up activities in the middle of bays suitable for the children in each area. Children in cubicles were also given activities to do.
- CAMHS children were referred directly on to the ward. If they required 1:1 nursing, this was requested from bank or agency staff.
- Staff told us that children with complex needs had to attend different appointments so their needs could be addressed.
- The service had a varied range of language translators available within the trust. If a translator could not be available in person, translation services were provided by a telephone service. However, there were no signage or leaflets available in additional languages. This meant the service did not address the needs presented by the diversity of the local population.
- Facing the Future Standards recommend there should be consultant presence on the ward at self-defined peak times. Hospital staff told us that their peak times were between 4pm and 9pm. The hospital had consultants' scheduled to be on site up until 5pm. We raised this issue with the trust. They confirmed that consultant presence during peak times was not in place. The trust advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.
- The service had a sensory room for children with learning disabilities.
- Staff at the hospital were participating in a study with Salford to improve communication for people with learning disabilities. This involved staff learning sign language so they could begin to communicate more effectively.
- In MDT handover meetings individual needs were discussed as well as individual discharge arrangements to ensure all staff were aware of plans.
- Parents were provided with a discharge letter. A copy of this was sent to the patient's GP either electronically or via the post.
- The trust told us play timetables were created for long stay patients e.g. children with fracture femurs.
- The trust told us parents with children receiving longer term care were provided with free on-site car parking.
- The Children and Young People's Experience Group helped develop a 'signalong' campaign with assistance from Salford University. All members of staff were taught one new sign per month.
- Neonatal parents had set up a Supporting Parents of Oldham and North Manchester Neonates group which met weekly at the trust.
- In response to an incident where a baby had not been identified, the neonatal unit had involved a clinical psychologist to improve bonding for the parent.

Learning from complaints and concerns

- At the time of our inspection the service had just produced its first trend analysis document for complaints and incidents in the Women and Children's division. This report identified the main themes as delay in treatment, staff attitude and communication.
- Ward managers were aware of complaint trends. However, there was no action plan in place to address the recommendations.
- In the division 63% of complaints were upheld or partially upheld.

Are services for children and young people well-led?

Inadequate

Overall in terms of being well-led, we judged that children and young people services at Oldham were inadequate. However, the quality of leadership and management within neonatal was stronger than the paediatric area.

Services for children and young people

Paediatrics

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

However,

- Quality and performance meetings were held on a monthly basis across the service's team. These covered the paediatric dashboard performance.

Neonates

- There was no strategy within the service. Most staff were unaware of the trust's wider vision and mission.
- There was not an effective system in place for identification and management of risks at team, directorate or organisational level.
- There was a divisional risk register that highlighted some but not all risks that were currently faced by the department. Staffing levels had been calculated but this did not always reflect the needs of the department.

However,

- In neonatal the culture was more positive and staff told us they felt supported.
- Neonatal team leaders had organised an audit programme and scheduled dates for the auditing to take place.
- Neonatal had plans in place to address the Dr Foster results regarding mortality.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- There was a Divisional Risk Register in place. However, we received five copies of the same document and all five registers contained different risks. We were not assured that managers within the trust were clear on current risks. Staff told us that the divisional risk register was circulated approximately four weeks prior to our inspection, prior to which they had not seen it.
- From the documentation provided, it was unclear which risks were current and whether appropriate actions had been taken to address risks.
- There was no departmental risk register. As such, all risks within the service were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate them in the longer term.
- Senior staff told us that risks were added to the risk register and were not reviewed. This meant the risk registers were not dynamic. Risks contained on one of the registers sent to us went back to 2007. The lack of a comprehensive dynamic risk register meant the trust board did not have a complete overview of risks within

the units or any current mitigating factors that were in place. This meant they could not provide an appropriate level of executive scrutiny or the required response to mitigate risks in the longer term.

- Senior staff were aware that incident reporting had recently decreased and that staff were not reporting all incidents. However, this was not recorded as a risk on the divisional risk register We were not assured senior managers within the trust had a clear understanding of the increased risk.
- Nursing staff, their managers and medical staff's managers were aware that all incidents were not reported. They were also aware that risk assessments were not completed and there were no departmental risk registers. We reviewed quality and performance meeting minutes. These issues were not recorded within these minutes. In view of this, it is difficult to ascertain how effective/reflective these meetings actually were.
- Senior leaders within the trust did not give sufficient priority to ensuring there was learning from serious incidents. We reviewed serious incident investigations and found limited evidence that actions resulting from the investigations were addressed. An audit to review the management of serious incident investigation and sharing of learning was scheduled for January 2016. At our inspection in February this had not taken place. This meant we had no assurance that the trust was giving this risk sufficient priority.
- In paediatrics there was a quarterly morbidity and mortality meeting where outcomes and lessons learnt into serious incidents were shared with medical staff. Nursing staff did not attend these meetings. Nursing staff told us they were unaware of the content of them, despite issues affecting nursing staff being discussed within them.
- The trust held monthly quality and performance meetings to address safety, clinical effectiveness, patient experience, performance and other divisional issues. The meetings were held at a trust wide level and again at departmental level. The departmental quality and performance meetings were held bi-monthly on the neonatal unit and quarterly on the paediatric unit. The trust told us that the minutes from the meetings were shared with all consultants, lead nurses and matrons for further dissemination.
- Neonatal services provided us with a detailed scheduled audit plan with dates for audits to be undertaken. This demonstrated evidence of effective workforce planning. We reviewed the recent audits that had been undertaken. Completed audits had recommendations and limited action plans that did not consistently address all the recommendations. Whilst action plans were included, it was not always clear when/if action plans had been completed.
- An audit plan was provided for paediatric services. This did not have planned dates for audits on it. This meant we had no assurance when/if audits had been undertaken and did not evidence how senior managers planned workloads nor had assurance that all audits would be completed within the timeframe. We discussed this with senior staff. They advised that the audits were scheduled. We requested the schedule, audits and action plans that have resulted from them but have not received them.
- The Trust performance in mortality reduction against other trusts nationally as shown in the Dr Foster Hospital Guide 2012 and through mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Indicator (SHMI) was shown to be deteriorating. The neonatal team recognised this and that efforts needed to be made to reverse this trend and ensure the drive to reduce avoidable deaths and avoidable harm. The neonatal team had monthly perinatal meetings where cases were discussed, actions were identified and learning was shared with paediatricians, obstetricians, neonatologists and trainees. Minutes from these meetings were shared with nursing staff, medical staff and multi-disciplinary team members by email and circulation of hard copies of the minutes.
- Neonatal staff attended a network clinical effectiveness group on a bi-monthly basis. Different topics were discussed throughout the network and best practice was shared.
- Quality and performance were monitored through the paediatric dashboard. This covered data such as sickness rates, new complaint, referral to treatment (RTT) rates and bed occupancy figures and additional information such as appointment cancellations and DNA (Did Not Attend) rates in the outpatients department.
- In paediatrics managers were aware that key staff within governance roles would be absent from the trust for a period of time. There was no continuity plan made for

this resulting in a gap in paediatric governance for over four months. Paediatric governance was identified as a high risk in a meeting in December, but was not added to the risk register.

- The paediatric clinical lead told us that in winter additional funds were not made available to paediatrics to enable them to provide additional nursing staff on the ward. Nursing leads told us booking of nursing staff had proved more problematic recently as the trust had stopped using a local agency due to costs. However, following escalation of our concerns regarding staffing, the trust started reusing the local agency. Senior staff told us that winter money for paediatrics had not been directed to the department. We were not assured that sufficient priority was given to quality care provision at the expense of meeting financial targets prior to our inspection.
- Paediatric staff told us that incidents and complaints were not fed back on a regular basis following their investigation.
- At site meetings there was not a regular nursing presence. This meant nursing staff were not consistently aware of issues arising.
- Senior staff told us that winter money for paediatrics had not been directed to the department.

Leadership of service

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

Culture within the service

- We found a culture where staff were used to not reporting incidents. We were told that incident reports were not always completed as staff did not see the point in doing this as frequently there was often no feedback or action taken. In addition to this, a range of staff believed and told us that incident reporting was not their responsibility. This meant that the board and senior leaders would not always be aware of issues that the department faced.
- In paediatrics there was an acceptance from staff that provision of basic nursing needs was acceptable and the provision of additional care and interaction was not essential.
- In paediatrics, consideration was not given to the totality of children's needs. For example one child with learning disabilities was bathed in full view of the nursing station. Consideration was not given to their dignity and respect.
- Paediatric staff told us that historically, human resources issues were not managed in a timely way to ensure the right people were in the right job. Middle managers told us that action was not taken to address

behaviour and performance issues that were inconsistent with the vision and values. For example when performance issues occurred documented evidence had not been collated.
- In neonatal the culture was more positive and staff told us they felt supported.

Public engagement

- The trust had introduced a text messaging service to obtain patient feedback.
- In the parents room the staff had introduced a board providing information. They asked parents for feedback on their understanding and amended things accordingly.

Staff engagement

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

Innovation, improvement and sustainability

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

End of life care

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

Information about the service

We visited Royal Oldham Hospital on 24 February 2016 as part of our comprehensive inspection of The Pennine Acute NHS Trust. The trust wide specialist palliative care and end of life care service is managed within the division of integrated and community services and operates across all four sites, North Manchester General Hospital, Royal Oldham Hospital and Fairfield General Hospital and Rochdale Infirmary.

Over the last two years the trust has reported a consistent number of deaths in hospital. From April 2014 to March 2015 there were 2703 deaths, of which, 1057occurred at Royal Oldham Hospital (ROH). From April 2015 to February 2016 the trust reported 2,494 deaths, of which 985 occurred at ROH. Given that the latest figures are only 11 months of data, this is consistent with the previous year's number of deaths.

In this trust end of life patients are cared for on general medical wards. There is a trust wide, consultant led, specialist palliative care team. At the ROH the consultant post is vacant and specialist palliative care input is led by specialist palliative care team (SPCT) nurses constituting 2.8 WTE. The SPCT at ROH received 705 referrals from 1 January 2015 to 31 January 2016. There is also a trust-wide end of life care team (1.8 WTE EOLC facilitators) based at the ROH.

We visited wards, F1 gynaecology, F7 respiratory, F8 coronary care F10 general medical, T3 vascular unit, AMU and accident and emergency

We looked at 15 sets of notes, spoke with five relatives and interviewed 30 staff members. These staff members included SPCT, junior doctors, ward staff, EOL link nurses, end of life service managers, a lead palliative care consultant, mortuary staff and bereavement office staff.

We also visited Rochdale Infirmary (RI) during the same inspection. This is the smallest hospital of the trust providing a very small level of in-patient services on the Oasis unit and a small clinical assessment unit (CAU). There were 24 deaths at RI from April 2014 to March 2015 and 29 deaths in the following eleven months. We were told that the Oasis unit has approximately six EOL patients each year.

End of life care

Summary of findings

End of life care at ROH was good in all domains apart from effective and well led which required improvement.

- There was no seven day service for SPCT out of hours and we identified three instances when patients suffered for longer than they should have when they were approaching the end of their life.
- Do not attempt resuscitation documentation (DNACPR) was not completed according to trust policy on four of occasions, particularly with regards to patients who lacked capacity.
- There was documentation in place which replaced the Liverpool care pathway. This document was called an individual plan of care (IPOC) but it was not sufficiently embedded into all ROH wards.
- There were depleted staffing levels of the SPCT at ROH and there were insufficient staff to implement a seven day service due to sickness.
- There was a vacant post for the consultant in palliative medicine, clinical cover and telephone advice was provided by the lead clinicians.
- EOL patients were not always cared for in ward side rooms There were only two side rooms on each ward and these could be taken up with other patients who had specific clinical needs, such as being infectious. We saw evidence on this when we inspected.
- The risk register for the service identified how not implementing a seven day service was a risk to patients , and noted there was a proposal to carry out a pilot project to remedy this risk. The pilot project made no mention of the extra staffing resources required to undertake seven day services, meaning that there was no robust, sustainable strategy proposed to address the identified risk.
- Also the risk to the service from failing to recruit to the consultant in palliative medicine post was not identified.

However,

- There was a policy and procedure for reporting of incidents and all staff were aware of how to complete incident reports. The EOL steering group identified that the monitoring of EOL related incidents required more accurate identification and monitoring and had set up a key word identification system for incidents. There was evidence of anticipatory prescribing for pain and symptom control in medical notes.
- End of life services were caring. We observed staff delivering care with kindness, compassion and respect. Relatives told us that the care their loved ones received was excellent, that pain was monitored regularly and they were treated with dignity. There was a multi-faith spiritual care team, who were trained to provide non-religious support to those patients and relatives who were not religious.
- We saw evidence that ROH EOL services were responsive to the needs of local people and to the needs of individual patients. The SPCT had a good understanding of the needs of the local population, worked as part of the multidisciplinary team and had good links with palliative care services in the community.
- Relatives of EOL patients were able to stay at the bedside of their loved ones, overnight and were given refreshments. Religious and cultural requirements were adhered to when patients died and when they were transferred to the mortuary.
- The trust had a clear statement of vision and values which was driven by national standards of quality of care and recognised safe practice. There were also good governance structures enabling robust monitoring of performance and quality of SPCT.

End of life care

Are end of life care services safe?

Good

End of life services at ROH are safe because:

- There were systems and procedures in place to report incidents and all staff we spoke with were aware how to report incidents. If SPCT noted a high rate of EOL related incidents on a particular ward they would develop a ward based programme to address identified issues. They reported that this approach had been successful in reducing incidents on targeted wards. The current system of identifying EOL related incidents does not provide complete coverage of incidents and a more accurate system of identifying them needs to be implemented and audited. Feedback should be given to those staff submitting incident reports so all staff are able to learn from incidents that are related to EOL. Patient's nursing notes should be stored in a secure manner on AMU.
- The trust had policies in place for prevention and control of infection and we observed those policies being put in action. The mortuary complied with all infection control requirements, but we did notice an unpleasant odour emanating from the cold storage room. Mortuary staff were aware of this issue and had undertaken extensive investigations as to the cause of the odour, but none could be found. The mortuary was licensed by the Human Tissue Authority (HTA) and had undergone an HTA inspection in November 2013.
- The trust participates in the national care of the dying audit for hospitals (NCDAH) and ROH achieved significantly higher than the national average for the percentage of patients receiving medication for control of five key symptoms as required. We saw evidence of anticipatory prescribing in medical notes and syringe drivers were readily available to ward staff when required.
- The standard of record keeping was good, in the notes that we reviewed, and contained all documentation that we would expect to see. Risk assessments were undertaken appropriately and regular observations were undertaken on EOL patients. Medical support was available promptly for EOL patients who deteriorated. All SPCT had undertaken the required mandatory training. Mortuary staff were a key part of the area major incident plan and had undertaken all required training.
- However there were insufficient staffing levels to meet the needs of EOL patients with complex care needs at the current levels. We found a complex arrangement with regards to SPCT staffing levels, with the most senior band 7 acting in the EOLC facilitation team for part of her post, in order to cover a vacancy. The band six was acting up to a band seven to fill the vacant hours. This meant that there was less than the planned 2.8 wte staff to cover ROH, which was not sufficient. The EOLC facilitation team also had less staff than its planned establishment. In addition, there was no specialist palliative care consultant at ROH, as the previous postholder had retired, which further reduced the capacity of specialist palliative care services at ROH.

Incidents

- There were systems and procedures in place for staff to report incidents and all incidents were reported via an electronic system.
- Specialist palliative care (SPC) nurses were aware of how to report incidents and gave examples of the types of incidents they would report. A SPC nurse told us how she completed an incident form when a patient's pain control had not been managed appropriately out of hours. It was not possible to locate this incident and it did not appear in the list of incidents submitted by the trust. Mortuary staff reported how an incident form had been completed when the correct procedures had not been followed for the release of a body. The bereavement office staff also demonstrated knowledge of the incident reporting system.
- There was no formal mechanism for staff to receive feedback on any incidents they submitted and staff reported that they didn't receive feedback on incidents. Staff reported that they felt frustrated by this and would welcome feedback about the incidents they submitted.
- The SPCT reported that if an event occurred that was in some way related to the SPCT they would discuss it at their team meeting and devise an action plan to address it. An example of this was that the SPCT noticed that one particular ward was not providing appropriate care for end of life patients demonstrated by a number of incidents of poor mouth care and lack of anticipatory medications being administered. The SPCT developed

and delivered a ward based training package which embedded learning. They noticed that the problems they had identified with end of life care resolved in this particular ward.

- We were informed that incidents for end of life care were monitored by the lead nurse for specialist palliative and end of life care. This monitoring was undertaken requesting a search by key word such as "end of life" and "palliative care". The incidents submitted by the trust did not appear to relate specifically to end of life care, which made it difficult to assess if end of life care incidents were being adequately monitored.
- Staff discussed a number of incidents with us that did not appear in the incident data we were given as EOL, which gave rise to concern that not all relevant incidents were being identified.
- Staff demonstrated an understanding of duty of candour requirements. All staff understood that they had a responsibility to be open and honest with patients and families when mistakes occurred.

Cleanliness, infection control and hygiene

- The trust had policies for the prevention and control of infection, which included a hand hygiene policy and the wearing of personal protective equipment. These were available on the trust's intranet and staff understood how to access them.
- Alcohol gel and personal protective equipment was available for all staff to use. Ward staff and the SPCT were observed implementing the hand hygiene policy.
- The mortuary was visibly clean and well ventilated. There was documentation to support a regular cleaning schedule. Mortuary staff complied with infection control policies and procedures and this compliance was regularly monitored.
- There was an odour present in the cold storage room. We were informed that although this had been fully investigated and all fridges thoroughly cleaned, no cause was identified and the odour persisted.
- Mortuary services were licensed by the Human Tissue Authority (HTA). The service had undergone a HTA inspection in November 2013 and HTA certification was visible in the Mortuary.

Medicines

- National Institute for Clinical Execellence (NICE) guidelines and the gold standard framework for patients at the end of their lives, "Just in Case", recommend that anticipatory medicines should be prescribed to alleviate the five key end of life (EOL) symptoms of nausea, vomiting, pain, shortness of breath and respiratory secretions.
- In the national care of the dying audit of hospitals (NCDAH), ROH achieved the organisational key performance indicator (KPI) for the prescription of medications for the five key EOL symptoms.
- The NCDAH includes a clinical key performance indicator measuring how many patients receive medication for the five key symptoms control as required (PRN). In the ROH 77% of patients received as and when required (PRN) medication for control of the five key symptoms experienced at the end of life. This was better than the England average of 51%.
- All medicines were prescribed using the electronic prescribing and administration system (EMPA). This system contained a palliative care bundle, which included information and guidance about anticipatory prescribing for pain and symptom control for patients' at the end of life.
- When patients were placed on the end of life individual care plan, anticipatory medicines were automatically included in the patient's prescribing plan.
- We saw that there was evidence of appropriate anticipatory prescribing in medical notes. This gave assurance that patients were receiving effective symptom management at the end of their lives.
- To administer symptom control medication for EOL patients, ROH used McKinley syringe drivers, which are portable, battery operated devices. The syringe drivers were kept in the electro-biomedical engineering department and could be ordered by ward staff as required.
- Staff reported that there were never any difficulties obtaining syringe drivers when they were required. They also reported that the process for requesting the syringe drivers was straightforward and that they were delivered promptly to the ward by the portering service following a request.
- The maintenance of the syringe drivers was carried out by the medical engineering department. Maintenance of medical equipment was governed by a policy and records of maintenance and service of the syringe drivers were kept. Records we reviewed indicated that the syringe drivers were serviced regularly.

Records

End of life care

- The trust used paper based records, with some patient information also kept on an electronic system.
- We looked at 15 patient records and all records were legible and signed by medical and nursing staff appropriately.
- The standard of documentation was high in all the records we reviewed. We saw that all of the following appeared, where appropriate, in the notes we reviewed; referrals to SPCT, multidisciplinary team meetings, 24 hour fluid balance, two hourly observations, recorded check of McKinley syringe driver and regular medication reviews. This provided assurance that important information regarding the care of the patient was recorded effectively.
- The nursing documentation on AMU was kept in each patient bay on top of the nurses' desk. This documentation was not stored in a safe and confidential way as any person could access a patient's documentation without proper authorisation.

Safeguarding

- There were safeguarding policies and procedures in place to protect adults and children. Safeguarding policies were held on the trust intranet and all staff we spoke with told us they were confident raising safeguarding matters and understood the safeguarding procedure.
- Safeguarding training was included as part of the trust's annual mandatory training. The training provided was levels one and two for adults and children.
- Information provided by the trust, which was confirmed in staff interviews, indicated that all SPCT nursing staff were up to date with all safeguarding training.
- From records provided to us and information given told to us be staff we were assured that all bereavement office staff and mortuary staff were up to date with safeguarding training.

Mandatory training

- The trust provided an annual mandatory training programme, to which staff at ROH had full access. This programme included fire awareness, safeguarding, information governance, moving and handling, clinical waste segregation, hand hygiene, infection control and equality and human rights training. All SPCT staff, bereavement office staff and mortuary staff had received the full mandatory training programme. This was confirmed by staff we spoke with and data received from the trust.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used in ROH to alert staff to any deterioration of a patient's condition. This was a set of manually recorded observations such as respiratory rate, temperature, blood pressure and pain score.
- We reviewed 15 sets of notes and in those notes we found evidence of appropriate risk assessments being undertaken and reviewed. The risk assessments that we identified as regularly completed in the notes were falls, nutrition (MUST), venothrombus embolism (VTE), pain and pressure areas.
- Ward staff reported that when an EOL patient was placed in a side room intentional observation rounds were undertaken. Intentional observation rounds are a method by which nursing staff assess the comfort of patients. This was confirmed from our review of patients' medical notes.
- Ward staff confirmed that medical staff responded promptly when a patient was identified as deteriorating. We were assured that any deterioration in a patient's clinical condition was escalated to the appropriate clinician.

Nursing staffing

- The SPCT was managed across the trust by the Macmillan associate lead cancer and palliative care nurse. Each site had its own allocated SPC staff and cover was only provided across the sites on rare occasions.
- We received documentation which stated that the Macmillan specialist palliative care nurse staffing establishment at ROH was 1.8 whole time equivalent (wte) band seven and 1 wte band six.
- We found that at ROH, the SPCT actual staffing levels were below the planned staffing levels. The actual staffing levels were 1wte band 6, who had been acting up to a band 7, whilst staffing levels were low and 0.5 band 7. Staff reported that the reduced staffing levels were impacting on the team's ability to provide the level of support and training they would if they were fully staffed.

End of life care

- There was a trust wide EOLC team which was based at ROH. This team provided specialist training in the treatment and management for patients approaching the end of their lives. They had provided the training for the IPOC implementation. The actual staffing for this team were below the planned level. This staffing deficit impacted on the team's ability to roll out the transformation programme and embed the use of Individual Plan of Care (IPOC) across all ROH wards.

Medical staffing

- At ROH there was joint funding for one consultant post and this post was previously divided into three areas of responsibility, 0.3 WTE consultant in palliative medicine at ROH, hospice consultant in palliative medicine/ medical director for the hospice and consultant in palliative medicine for the community. The previous post holder had retired and a new consultant had not been recruited. There was no specialist consultant cover at ROH for palliative care, however there was cover by telephone from the clinical lead.

Major incident awareness and training

- The major incident plan was held on the trust intranet. We also saw major incident files in the mortuary and in the bereavement office.
- The mortuary at ROH had 102 spaces and was an essential part of the trust and community major incident and mass fatalities plan. All mortuary staff undergo three training days each year as part of major incident planning to identify where problems might arise.

Are end of life care services effective?

Requires improvement

End of life services at ROH required improvement to provide effective services because:

- There was no seven day service for SPCT at ROH. The SPCT service operated between 8.30am – 4.30pm Monday to Friday. This was further compounded by the fact that there was no specialist palliative care consultant operating on site. The lead specialist palliative care consultant on informed us that the two consultants on other sites would provide advice and support to junior doctors when needed out of hours and at the weekend. This does not reflect the national guidance set out by the national leadership alliance. In any event, junior medical staff did not appear to be aware of this possibility and requested supported from their own specialty.
- We were also told that medical staff could request support from a local hospice telephone line regarding complex symptom control. However, there was no service level agreement in place to support this service. Junior doctors reported that they had not used the service. Three occasions were reported to us where patients suffered more than they should have done, because there was no out of hours support for EOL care. A junior doctor reported that he didn't feel confident adjusting medication to the levels asked of him by nurses and there was a delay before a more senior doctor came to see the patient. A SPCT member identified a patient whose pain and other symptoms were poorly controlled overnight. We were told that an incident form was completed for this patient but we could not trace it. We observed in medical notes an occasion when an interventional radiologist refused to drain ascites from a patient's abdomen because it was the weekend. The lack of seven day and out of hours specialist palliative care service was aggravated by the fact that there was no formal training programme for middle grade medical staff in the management of complex symptom and pain control.
- Training was provided to medical staff on induction regarding the correct procedure to be followed for completion of documentation to support a decision of do not attempt cardio pulmonary resuscitation (DNACPR). However, a review of 15 medical notes identified that this procedure was not being correctly documented in four cases. All staff received mental capacity act training as part of safeguarding training. In two cases medical staff had signed documentation to support the decision not to resuscitate and stated that the decision was made because a person was confused or frail, which is not a valid reason for not offering DNACPR. There was no evidence of a mental capacity assessment being undertaken for these patients. In some instances where a decision was taken and the patient was not capable of consenting to it, there was no discussion with relatives noted on the documentation itself. This was contrary to the trust's own policy.

- These instances of poor practice relating to the documentation supporting a decision not to resuscitate were escalated immediately with the executive nurse and chief executive. This was addressed immediately with the medic concerned.
- An individual plan of care (IOPC) had been developed, in line with national guidance, and its use was embedded in the two transform wards, F7 and F10. Transform wards are wards which have been identified as leading the implementation of the new documentation IPOC. It was being used on other wards but not consistently. We reviewed three sets of medical notes from deceased individuals who would have benefited from staff using the IPOC but they were not placed on it. On some wards staff reported that they didn't feel confident using it and required more training. A second cohort of transform wards, AMU and G2 had been identified for intensive support and training using the IPOC and this was to take place in the near future.
- The hospital took part in the NCDAH in 2014 and again in 2015. The most recent results had not yet been published, so performance from 2014 is quoted in this report. The ROH achieved four out of seven of the organisational performance indicators. For three of out of ten clinical indicators it performed around the England average and for the remaining seven it performed below the England average.
- Pain relief was assessed using a numerical pain score which was verbally confirmed by the patient. A pain scoring method for patients with cognitive impairment was introduced the week before our inspection. Staff reported that they did not feel confident using it and required more training. Medical notes we reviewed documented that pain was assessed and reviewed regularly. This was confirmed by relatives we interviewed.
- Nutrition and hydration of EOL patients was assessed and reviewed regularly. Staff in the SPCT were competent and there was strong evidence of effective multidisciplinary working.

Evidence-based care and treatment

- The SPCT worked in line with best practice and national guidelines such as the national institute for health and clinical excellence (NICE). They also worked within guidelines provided by the strategic clinical network for Greater Manchester, Lancashire and South Cumbria. An example of this is that the prescribing guidelines for end of life patients, set by the strategic clinical network, were adopted by the EOL steering group and implemented across the hospital.
- The end of life care strategy was based upon national policies and NICE guidelines. The trust's end of life care plan had previously been based upon the Liverpool Care Pathway, but this was withdrawn in 2014 and an individual plan of care (IPOC) had been developed.
- The IPOC was developed in line with national guidelines. The trust decided to implement the IOPC on a rolling programme basis with two wards on each site acting as pilot wards. At ROH the two wards chosen as pilot wards were F7, a respiratory ward and F10, a general medical ward. We saw examples on both of these wards of the IPOC being used.
- The SPCT had identified end of life link nurses for all wards, who acted as cascade trainers for dissemination of the IPOC. We found that although staff on all the wards we visited were aware of the IPOC, it was only the transform wards where it was being used on a regular basis. Staff we spoke with said that they were too busy to implement it or that they didn't feel confident using it at this time and would require more training. This did not provide assurance that staff had been fully engaged with the training to enable them to implement the new documentation.
- The exception to this was AMU, where staff reported that they did use IPOC. We were not able to look at any medical records to confirm how AMU staff used the IPOC because the sets of notes for end of life patients were not available at the time of inspection. These notes were not available at the time of inspection because they were in use by clinical staff.
- When staff did not use the IPOC they documented the care plans and care received by patients in general medical notes. The SPCT recognised that ward staff needed more support to implement the IPOC and had identified two more wards (AMU and G2) for further training and support in the manner of the pilot wards. Medical staff that we spoke with had not received training in the use of IPOC, although we saw evidence that information would be sent out to medical staff about the document in the future.
- There was an audit plan in place as part of the transform programme. A baseline was established for staff

adherence to the available prescribing guidance, the documentation of patients' pain or symptoms and symptom control at the end of life. An action plan was developed from the results of this audit.
- Mortuary staff adhered to the protocol for deaths as set out in the EOL policy. An example of this is mortuary staff observed cultural and religious requirements for all deaths.
- A trust wide audit of adherence to the national standard, as defined by Hospice UK guidelines, that all deceased persons should be transferred to the mortuary within four hours of death. The standard across the trust was achieved in 53% of cases.

Pain relief

- Patients' pain at the EOL was assessed using a numeric rating scale for patients who could verbally report pain. A pain tool for assessing patients with cognitive impairment had just been developed but was not in use at the time of inspection. This tool was based on staff identifying visual cues to assess pain. It was anticipated that training would begin on the cognitive impairment pain score in the coming months. The IPOC contained a tool for the non-verbal assessment of pain.
- There was a pain link nurse on every ward who cascaded training and provided support to ward staff.
- One relative reported that staff came in regularly to assess pain, identified when his father was having breakthrough pain and addressed these needs. The same relative reported that his father's syringe driver was prepared in advance, by nursing staff, so that there was less disruption when the time came to change it.

Nutrition and hydration

- The 2014 NCDAH identified that at ROH 53% of patients had their nutritional status reviewed. This was better than the England average of 41%. The NCDAH also identified that 51% of patients had their hydration status reviewed, which is the around the same as the England average of 50%.
- In the medical notes we reviewed, we found evidence that patients nutritional status was risk assessed using the malnutrition universal screening tool (MUST) and fluid balance was recorded.
- The relatives we spoke with reported that all food and drink needs were met in a way that was appropriate to their relative.

Patient outcomes

- In the NCDAH 2014 ROH achieved four out of seven organisational key performance indicators. These were access to information relating to death and dying, protocols in place for the prescription of medicines for key symptoms at end of life, clinical protocols protecting privacy, formal feedback processes for bereaved relatives.
- ROH performed at around the same or better than the England national average in three out of 10 clinical indicators. These were medications prescribed as required for the five key symptoms and reviews of nutritional and hydration status of the dying patient.
- The NCDAH also identified that at ROH there was multidisciplinary recognition that a patient was dying in 42% of cases. This was worse than the England average of 61%. This supports staffs' concern that not all people who were dying were identified as such and were not put on to an IPOC. When we reviewed notes of individuals who had recently died, we saw that although patients were not always identified as dying and were not on an IPOC, anticipatory medications were administered and discussions with family about stopping treatments had taken place.
- We spoke with three sets of relatives of EOL patients. All three families stated that they were extremely happy with the care delivered to their dying relative. They reported that the care and treatment given was compassionate and focused on making their relative comfortable.

Competent staff

- The SPCT at ROH had received their annual appraisals. The trust had arrangements in place for all clinical nurse specialists to receive clinical supervision, but the SPCT nurses did not attend this supervision and therefore didn't receive clinical supervision. SPCT nurses reported that they did not receive clinical supervision.
- The SPCT and the EOLC facilitators had developed a modular training programme for the EOL ward link nurses. The link nurses then delivered cascade training on their own wards. It was reported to us that all ward had identified link nurses and that cascading training was in the process of commencing. The two transform wards had completed this programme.

- If SPCT identified a need they would set up a six week rolling programme on a ward to deal with specific EOLC. They had done this on a number of occasions and it had been a very successful way of addressing EOLC issues.
- We were informed that all mortuary staff are qualified to certificate and diploma level.

Multidisciplinary working

- The SPCT reported strong working relationships with wards staff, which was echoed throughout all discussions with ward staff. They attended weekly multidisciplinary ward meetings were possible.
- The ROH SPCT had very strong community links. They attended the local hospice multidisciplinary team meeting once a week where all new referrals were discussed. The also had good links with the community Macmillan specialist palliative care team.
- The use of an electronic palliative care co-ordination system assisted communication across the wider healthcare system. We were informed that this created good communication between healthcare professionals as the patient moved around the wider healthcare system.

Seven-day services

- ROH did not provide a seven day SPCT service. The SPCT work Monday to Friday 8.30 to 4.30 and did not provide any cover outside of these hours.
- This situation is compounded by the fact that there is currently no specialist palliative care consultant provision at all, however there is access to telephone advice. This means that junior medical staff do not get the benefit of consultant advice and training on issues relating to complex symptom control and pain management Monday to Friday, which would assist them dealing with patients out of hours. The lack of a specialist palliative care consultant is further aggravated by the fact that there is no formal training in EOL care for middle grade medical staff.
- After 5pm there is a hotline available which is staffed by Dr Kershaw's hospice. All staff can contact this hotline for advice regarding symptom control, but as there is no formal service level agreement to support this arrangement there are no clinical governance arrangments that to support junior doctors in their decision making process. Junior doctors stated that they had never used this service and were unlikely to call on it in the future.
- The lack of seven day service was identified as a risk on the trust risk register. The potential impact of this risk was identified as increased length of stay for palliative care patients out of hours, risk of inappropriate admission of palliative care patients out of hours, uncontrolled symptoms for palliative care patients out of hours, reduction in the patient/carer experience, increased risk of patient not dying in their preferred place of death and increased risk of drug errors in relation to SPC prescribing.
- The EOL risk register stated that actions taken to reduce the associated risks included undertaking generic palliative care training for clinical teams and ensuring the delivery of pre-anticipatory planning and prescribing for patients known to SPCT. There was limited evidence this was taking place. Foundation years 1 and 2 doctors received training as part of their induction but no other training was offered to medical staff.
- A SPCT identified difficulties with patients receiving appropriate levels of medication for adequate symptom control out of hours. Two staff reported that they had submitted incident forms after a specific incident had occurred. We were not able to identify these incidents through the reporting systems. This did not provide assurance that effective systems had been established to identify and monitor incidents that placed EOL patients at risk.
- The strategy for palliative and end of life care stated that a pilot project would be established in July 2016 to inform future provision of seven day services and inform the business case.
- The current staffing levels were not sufficient to provide a seven day service and a pilot project would require an increase in numbers of SPCT.
- We were able to identify two further examples where patients did not receive the care they required out of hours. In one set of notes it was noted that the interventional radiology department refused to drain a patient's ascites, (fluid in the abdominal cavity), over the weekend. In a second example of junior doctor told us that he did not feel comfortable with the level of medication he was asked to prescribe to an end of life patient. This doctor did not ask the 24 hour hospice service for advice but did refer the issue to his senior, which created a delay of some hours until the patient received the medication they required.

End of life care

- The bereavement office was open to relatives Monday to Friday 8.30 to 4.30pm.
- The mortuary was open Monday to Friday 8.00-5.00pm. If relatives wished to view a deceased person outside of this time, special arrangements were required to be made.

Access to information

- For patients at the end of life their wishes regarding preferred place of care and death were recorded in their case notes. If patients had an IPOC their wishes were recorded in IPOC.
- SPC staff reported that these wishes were not routinely recorded for patients at the end of life with non-malignant disease. We were told that this had been identified as a gap at education meetings and a training programme was in the process of being planned for specialist nurses and ward based teams.
- If patients were identified as at the end of their life they were discharged with an electronic palliative care handover form. This form notified their GP of SPCT involvement with their care.
- SPCT reported that the DNACPR did not always accompany the patient into the hospital and a training plan had been developed to tackle this across the healthcare system. The DNACPR did accompany the patient to place of care on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place. This policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of independent mental capacity advocates.
- All staff received mandatory training regarding mental capacity and deprivation of liberty safeguards as part of safeguarding training.
- Training in DNACPR for doctors was provided on induction by the trust wide lead specialist palliative care consultant, training input is also provided in both FY1 and FY2 teaching programmes. This training involved trust policy and the procedure to be followed when making a decision not to resuscitate a patient at the end of their life.
- During our inspection, we reviewed DNACPR documentation in 15 sets of notes. Although some documentation was correctly filled out, there were errors in four of the DNACPR forms we reviewed. In two cases there was no reason noted for the DNACPR and in another two reasons for the decision were recorded as "frailty" or "confused". Where patients lacked capacity to be involved in the decision, there was no evidence of mental capacity assessment being undertaken. In one case where a patient lacked capacity, medical staff had noted on the DNACPR that the decision had been discussed with relatives. However, we observed in the medical notes that after the notice had been signed family complained that they had not been consulted. These issues were consistent with errors noted during a trust audit in November 2014.
- An education post for DNACPR was appointed to in October 2015 and the post holder commences in May 2016.

Are end of life care services caring?

Good

End of life services were caring because:

- Staff treated patients at the end of their life with compassion and empathy. We were able to observe staff interacting with EOL patients and relatives and noted that they were treated with kindness and dignity. A butterfly symbol was used by staff to promote privacy and dignity for patients at the end of their lives and their relatives. The trust wide bereavement survey 2015 reported that from the 15 relatives who responded to the survey at ROH, the majority considered that they were treated with respect and dignity by staff. Almost all respondents reported that met their loved ones care needs either always or most of the time. However, 53% per cent of relatives reported that the environment in which their relative spent their last days was not appropriate and the same percentage reported that they were not given the opportunity to be involved in their relatives care.
- There was an ecumenical, multi-faith spiritual care team at ROH, which provided emotional and spiritual support to end of life patients and their relatives and carers. There was a clear statement to provide emotional support only for non-religious patients.
- Mortuary staff had put in place procedures for the viewing of deceased relatives, which was

compassionate and kind. The viewing room at ROH was clean, well decorated and featured a non-religious stain glassed window, giving dignity and respect to the deceased.

Compassionate care

- Patients at the end of their life were treated with compassion and empathy. We observed staff interacting with patients and their relatives with kindness and consideration.
- The butterfly symbol was used to promote privacy and dignity for patients and their relatives. The butterfly symbol was promoted extensively across the trust, at training events on publications and on a screensaver. This promotion was to ensure that the symbol and its meaning was embedded into the delivery of care.
- There was a trust wide bereavement survey conducted in 2015. Fifteen relatives responded from ROH. The majority of people felt that their relative was treated with respect and dignity by all staff, especially doctors and nurses. Almost all relatives felt that staff met their loved ones care needs either always or most of the time. Eighty per cent of people said that they were given the opportunity to talk with doctors involved in their relatives care. Fifty three per cent of relatives reported that the environment in which their relative spent their last days was not appropriate. Fifty three per cent also reported that they were not given the opportunity to be involved in their relatives care. Fifty three per cent also stated that they were not given the booklet "help and information for the bereaved".
- The bereavement survey 2015 was discussed at the EOLC steering group in January 2016, where it was decided that a number of actions would be taken to increase the response rate.
- Once a patient was identified at the end of their life, an open visiting policy operated across the trust, which ROH implemented. Relatives were given a free parking pass without having to ask for it. The relatives we spoke with really appreciated open visiting and free parking.
- Mortuary staff were compassionate to bereaved relatives when supporting them to view their deceased relative. The process for viewing a deceased relative was designed with the distressed viewing relative in mind. Viewing was by appointment only between the times 8.00am to 5.00pm. However, a mortuary technician was available, in exceptional circumstances, to allow viewings until 8.00pm Monday to Friday. The appointment system was in place to avoid more than one family attending the viewing room at one time. There was a separate entrance to the mortuary for families. One waiting room was available, where a family could wait whilst another family was in the viewing room. All mortuary facilities were accessible for people using a wheelchair.
- Mortuary staff prepared families for the viewing of their deceased relative, explaining any injuries that they had acquired around the time of death.
- The viewing room was clean and simply, but pleasantly decorated. There was a large non-religious stained glass window and simple flower decoration. The deceased person was dressed and covered in a dignified and sympathetic manner.
- Mortuary staff reported to us that they gave relatives time alone with deceased if they wanted it and that they asked all relatives if they did wish to spend time with their deceased loved ones.

Understanding and involvement of patients and those close to them

- The relatives we spoke with reported that staff involved them in all aspects of decision making about their loved ones. They also reported that they could be involved with care as much as they wanted to be. There was also evidence of patient and relative involvement in care throughout the medical records that we reviewed.
- The bereavement survey 2015 found relatively low levels of relative/patient involvement with care. Only 53%, eight, of those interviewed said that they were involved in decisions about their relative's end of life care and only 33% stated that their dying relative was involved in decisions about their care. The survey reported low levels of patient and relative involvement in decisions about different aspects of care such as preferred place of care, resuscitation status, decisions to stop invasive treatments, symptom management and level of care, for example whether a patient was transferred to an intensive care unit.
- We found the evidence for patient involvement to be contradictory and all the evidence we had involved relatively low numbers considering the numbers of deaths at ROH. The strongest evidence was from relatives who we met caring for their loved ones during their last hours. These relatives reported that they were fully involved in all aspects of their loved ones care.

End of life care

- The trust EOL steering group identified the need to increase the response rate for the bereavement survey 2016.

Emotional support

- The ecumenical, multi-faith spiritual care team provided emotional and spiritual support to end of life patients and their relatives at ROH. The focus of this team was emotional support and/or spiritual support, which included stress reduction techniques and a focus on the peace and comfort of the patient. There was a clear statement for the provision of emotional support only for non-religious patients. For religious patients religious texts, bedside sacraments and prayers were available. The spiritual care team developments were identified in trust priorities for their EOLC role.
- The spiritual care team consisted of religious leaders from different faiths and volunteers who were trained in counselling skills. The team was available 9.00am-5.00pm but also provided 24 hours on-call service.
- The lead chaplain gave a list of EOLC patients who required support to the volunteers and they visited them on the transform wards F7 and F10. The volunteers also called onto these wards to see if nurses had identified patients in need of support. Volunteers provided comfort orientated care as well including hand massages, mouth care and drinks.
- At ROH there was a Christian chapel open from 6.00am to 6.00pm. There was a Muslim prayer room, which had a separate women's space, and was open 24 hours a day.
- The SPCT provided emotional support for those patients who had complex symptom needs and had been referred to them. The SPCT encouraged ward nurses to provide emotional support to those EOLC patients who did not require SPCT input.

Are end of life care services responsive?

Good

End of life services were responsive because:

- We saw evidence that ROH EOL services were responsive to the needs of local people and to the needs of individual patients. The SPCT had a good understanding of the needs of the local population, worked as part of the multidisciplinary team and had good links with palliative care services in the community.
- Where possible EOL patients were cared for in ward side rooms. However, this was not always possible as there were only two side rooms on each ward and these could be taken up with other patients who had a greater clinical need, such as being infectious. We saw evidence on this when we inspected. Relatives of EOL patients were able to stay at the bedside of their loved ones overnight, and were given refreshments. Religious and cultural requirements were adhered to when patients died and when they were transferred to the mortuary.
- Access to the SPCT, between the hours of 8.30 to 4.30 was good and all those patients who required input for complex symptom management were seen by the SPCT. The team appropriately triaged patients and could see them within the same day, depending upon urgency. There were two rapid discharge processes for EOL patients. One was for transfers of care for EOL patients wishing to move to their preferred place of care. The second was for patients with whom the SPCT were involved and required rapid discharge support involving the management of complex symptom control.
- There was monitoring of complaints from EOL patients and relatives, however, there was some concern that complaints were being missed. In response the EOLC steering group had initiated a project to search for complaints by key words. The EOLC steering group monitored complaints to the service. There had been no complaints about the SPCT in the past 12 months.

Service planning and delivery to meet the needs of local people

- The SPCT had a good understanding of the needs of the local population. Ward staff and the SPCT reported that the team worked as an integral part of the multidisciplinary team, which was evident in the medical notes that we read.
- The SPCT had good links with community teams outside of the hospital, including GPs, district nurses and community SPCT. These established links supported consistency of care for patients who moved between care settings.
- The SPCT communicated with ward staff on a daily basis regarding patients referred to the SPCT. Ward staff reported that if they required advice and support for

complex symptom control, the SPCT responded promptly to referrals, usually within 24 hours. We saw evidence of this prompt response in patient notes that we reviewed.
- The SPCT reported that they did see all patients referred to them who required complex symptom control and management. However, if patients were referred purely for emotional or psychological support, the SPCT signposted ward staff to more appropriate support services or encouraged ward staff to provide that support for patients. The SPCT also provided support and advice over the telephone to ward staff.

Meeting people's individual needs

- All the teams and individuals we met were committed to providing individualised care and treatment to end of life patients and their relatives. Once a patient was identified as entering the end of their life, the multidisciplinary team attempted to support individuals with their all their care preferences and needs.
- Where the new IPOC was being used, we saw care preferences documented. We also saw anticipatory medications being prescribed, discussions with relatives about DNACPR and preferred place of care and death. These discussions were also evident in the medical notes of patients that were not placed on IPOC.
- Ward staff attempted to move patients who were at the end of life to single side rooms. This was not always possible as there were only two side rooms per ward. We visited one ward with two end of life patients, neither of whom the ward were able to place in a side room. This was because both of the side rooms on this ward were being used by patients who had contagious infections. This meant that patients and relatives were not always able to be cared for in a private setting in the last hours of their life.
- If a patient was being cared for in a side room, relatives were able to sleep at the bedside of their loved one, with ward staff providing a mattress and refreshment facilities. They were also provided with free car parking passes by ward staff. The relatives that we spoke with who were caring for their loved ones as they approached the end of their life reported that staff provided care focussed on individual needs.
- In the mortuary there were 14 cold storage bariatric fridges.
- Mortuary staff adapted their practice according to religious needs. There was a policy in place for accelerated release of deceased persons for cultural and religious requirements. Mortuary staff turned the heads of Muslim deceased to the right and ensured that the faces of the Jewish deceased were covered.
- If a relative was a wheelchair user, the deceased was placed on an adapted trolley, which enabled the relative sit at the bedside at the appropriate level.
- We were assured that mortuary services did take account of the individual needs of the deceased and their relatives.

Access and flow

- Referrals to the ROH SPCT could be made electronically or by phone. The SPCT triaged the referrals as they came in, signposting them to other services if required. Those patients deemed as most urgent were seen within the same morning or afternoon session. SPCT and ward staff reported that most patients were seen within 24 hours during the working week.
- As part of EOL strategy two rapid discharge processes were in place at ROH. The first was a rapid transfer of care for EOL patients requiring a fast track discharge to their preferred place of care. We observed this process on one ward where an end of life patient was being transferred to a hospice bed. All arrangements were able to be made within 24 hours, including a rapid transfer ambulance. The second rapid discharge scheme, the rapid transfer pathway for those EOL patients referred to the SPCT and required complex rapid discharge to their preferred place of care in the last 24 hours of life. This service was piloted at ROH and was embedded into the discharge process for those patients who required it. Staff were confident initiating both processes and were very proud of how responsive these discharge pathways were to individual patient needs.
- There was an increased demand for mortuary spaces due to the increased number of post mortems being requested. Mortuary staff reported that they could now wait for a coroner's decision for up to 10 days. This had the effect of causing an increased demand for mortuary spaces because deceased individuals were staying longer. We were told that when demand was particulary high, bodies were stored at Fairfield hospital, where the trust had created more capacity.

Learning from complaints and concerns

- Complaints regarding EOLC were dealt in the speciality to which the patient was initially admitted, which could

lead to SPCT not being aware of the complaint. This was changing and in future the EOL steering group would receive any complaints regarding EOLC. At ROH the SPCT reported no knowledge of any complaints about the service over the past 12 months.

Are end of life care services well-led?

Requires improvement

End of life care services at ROH were Requires Improvement in the well-led domain because:

- The trust had a clear statement of vision and values which was driven by national standards of quality of care and recognised safe practice. The statement of vision and values was incorporated into the EOLC strategy, governed by the EOLC steering group. There were robust governance structures in place to monitor quality and performance of the work of the EOLC steering group and the SPCT. There was trust board involvement in the work of the EOLC steering group. There were clear leadership structures which were involved in the governance of the SPCT service.
- There was a compassionate and caring culture amongst all staff delivering services to EOL patients, which extended to staff in the mortuary and bereavement office when dealing with relatives of the recently deceased. The morale of all staff we spoke with was high and they felt supported by managers. The morale of the SPCT was also high considering the difficulties they were experiencing with staffing levels. These staff reported that they were aware of the potential for "burn out" and dealt with it by consciously raising the issue and providing support to each other. They reported that they recognised continued service delivery at the current staffing levels was not sustainable in the long term.
- However, although the risk to the service of not implementing a seven day service was identified and there was a proposal to carry out a pilot project to remedy this risk, there was no robust, sustainable strategy proposed to address this risk. The failure to fully identify and address the risks to the service was reflected in the leadership of the service, which was good apart from these points. There were a number of wide-ranging planned developments in the EOLC strategy, but the reduced number of SPCT at ROH nurses meant that the sustainability of these plans, for ROH, was questionable.

Vision and strategy for this service

- There was a trust wide strategy in place for palliative and EOLC. This strategy articulated a clear vision for EOLC and identified that EOLC is the remit of the whole trust, not just the SPCT and EOL facilitators. The strategy was based upon national guidelines and good practice as identified in the national policy "ambitions for palliative and end of life care". The ROH SPCT understood the strategy and vision for EOLC and contributed towards its implementation. Most ROH ward staff we spoke with demonstrated understanding of the strategy and shared the trust vision for EOLC. This was evident in their commitment to identifying EOLC link nurses for each ward and keeping up to date folders for EOLC in prominent places on wards.
- There was an identified member of the trust board with responsibility for implementation of the strategy, which was the chief nurse. ROH SPCT reported that they felt well supported by the chief nurse, who they believed understood the strategy and promoted the aims and vision of it.
- Implementation and oversight of progress towards implementing the vision was the responsibility of the EOLC steering group.

Governance, risk management and quality measurement

- There were robust governance procedures in place to monitor the implementation of the EOLC strategy and performance of palliative care at ROH. The EOLC steering group met on a quarterly basis and monitored information related to performance and quality for palliative care. This included complaints, incidents and bereavement care. The EOLC steering group recognised that there was a problem identifying relevant data, which resulted in incomplete coverage for the data sets. Actions were being taken to address this which included the introduction of key word searching for incident reports.
- The robust governance procedures for EOLC were supported by a trust governance structure which facilitated regular reporting of EOLC performance within the division of integrated and community services.

Quality and performance information and data was communicated within the division by means of monthly highlight reports to the divisional quality and performance committee meeting and the divisional management team meeting. Annual and bi-annual Macmillan service review reports are prepared for the corporate quality and performance committee. The non-executive member of the trust board, with responsibility for palliative and EOLC was a member of this committee.

- There was a trust risk register, which included identified risks for the SPCT. The risk identified was that difficulties providing a seven day service on current staffing levels, as identified earlier in this report. Although this EOL steering group intended to address this risk by undertaking a pilot of seven day working, there was no evidence that the critical point of this risk, lack of SPCT nurses, was being addressed. The failure to recruit to the vacant consultant in palliative medicine post was not identified as a risk to the service.
- The mortuary was in the diagnostics and clinical support division and mortuary staff attended monthly meetings at the ROH. At this meeting governance issues were addressed and minutes of the meeting were taken and disseminated for all staff.

Leadership of service

- The work of the SPCT and EOLC was overseen by the EOLC steering group. This group was chaired by the lead consultant in palliative medicine. There was trust board involvement in the leadership of the service through the chief nurse and non-executive lead.
- The SPCT was managed by the Macmillan associate lead cancer/palliative care nurse. There was an operational policy in place for the SPCT which included clear statement of governance structures.
- The SPCT reported that managers were approachable, visible and that they felt comfortable reporting difficult matters to them.
- It was not clear that the leadership of the service understood fully the challenges involved in establishing a pilot project for seven day working on current staffing levels.
- There was no audit or review of the impact of losing the only palliative care consultant at the ROH.

Culture within the service

- All the staff we spoke with were dedicated to providing the highest standard of care to patients and relatives and the deceased. Staff demonstrated compassion and understanding to patients and relatives in all the areas we visited. Staff were focussed upon the needs of patients, relatives and the deceased, recognising that they had a very important role to play in people's lives at a difficult time.
- Morale was very good in the mortuary and bereavement office and staff felt supported by managers. Morale was also good in the SPCT, even though they were depleted of nursing staff and a consultant. Even with the reduced numbers of staff the SPCT were highly motivated and positive about the treatment they provided to patients and support they provided to ward staff. These staff reported that they were aware of the potential for "burn out" and dealt with it by consciously raising the issue and providing support to each other. They reported that they recognised continued service delivery at the current staffing levels was not sustainable in the long term.
- The SPCT demonstrated a culture of constant review of the service they provided.

Public engagement

- The EOLC steering group identified the importance of patient, family and carer input into planning the future provision of services. Bereavement surveys were carried out in the preceding two years and feedback from these surveys influenced the direction of the service provision. An example of this was the identification of the need for a comprehensive bereavement service.
- The service participation in the NCDAH included feedback from patients which the EOLC steering group included in EOLC strategy.

Staff engagement

- The ROH SPCT felt involved in decisions about the service and reported that they felt supported by the trust.

Innovation, improvement and sustainability

- The EOLC strategy outlined a large number of wide-ranging developments to be implemented in the next year. This included better data collection for the SPCT, evaluation of ward pilots for transform wards, rolling out of the second cohort wards of the transform programme and review of existing gaps in the rapid

transfer pathway. The planned pilot project for the transition to seven day working is included in these developments. The SPCT is heavily involved in these planned developments.

Outpatients and diagnostic imaging

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

Information about the service

The Royal Oldham Hospital offers a range of different outpatient clinics held at several different locations around the hospital site, mainly at ground level. In the main hospital building was Outpatients A and Radiology. At a lower level on the site, in separate buildings, at a lower level on the site was Outpatients B (housing children's outpatients); outpatients C (housing chest and dental clinics); the Diabetes Centre at the rear of the lower level site and the Lucy Pugh oupatients building that was next to the main hospital building but at the bottom of a very steep slope. It could be accessed from inside the main building (that could be accessed at ground level) but via a long corridor and a lift.

The hospital provides a combination of consultant and nurse-led clinics for a full range of specialities. The clinics included: Breast surgery; cardiology; clinical haematology; colorectal surgery; diabetic medicine; endocrinology; ear, nose & throat; gastroenterology; geriatric medicine; medical oncology; pain management; respiratory medicine; trauma and orthopaedics; urology and vascular surgery.

The trust holds 508 outpatient clinics per week. Oral and maxillofacial surgery; Gynaecology; Ophthalmology and Paediatric clinics were managed separately within their respective divisions. There are 37 anticoagulant clinics per week across hospital and community settings.

Across the trust, the top five speciality clinics by volume of attendances were anticoagulant services; trauma and orthopaedics; obstetrics; ophthalmology and urology. These clinics made up 46% of all attendances. Anticoagulant services had the highest number of attendances.

Between July 2014 and June 2015 the Pennine Acute Hospital NHS Trust had 701,767 outpatient appointments of which 228,850 were first attendances and 473,482 were follow up appointments. Because the majority of anticoagulant therapy is life long, new to follow up rates for these services did not apply.

From January 2014 to June 2015, there were 237,080 outpatient appointments at The Royal Oldham Hospital, an average of 13,171 per month. The average numbers of patients attending per month in the first six months of 2014 to the first six months of 2015 had remained almost the same with an increase of less than 1% in attendances. However, there had been a 78.8% increase in attendances at nurse-led activities when comparing the first six months of 2014 to the first six months of 2015, an average increase of 543 patients per month.

The hospital also provides a range of diagnostic imaging services to patients including: Radiology (general radiography, x-rays), computerised tomography (CT) scanning, magnetic resonance imaging (MRI), angiography (pacemaker insertion); ultrasound; vascular ultrasound; DEXA (Dual energy x-ray absorptiometry); breast imaging services and interventional radiology (IR). Nuclear medicine and neurophysiology for the trust was operated out of North Manchester General Hospital.

We also inspected the pathology laboratories at The Royal Oldham Hospital. All GP and day-to-day pathology work for

Outpatients and diagnostic imaging

the trust went through the Oldham laboratories that were housed in a 3-storey building on site. The building had been commissioned in 2007 and over £17 million had been invested in the services provided. There were haematology and biochemistry laboratories at Fairfield General and North Manchester General Hospitals but these were essential use laboratories.

The trust receives over 900,000 haematology requests and over 30,000 units of blood are transfused per year. The trust carries out over 7.5 million clinical biochemistry tests per year. The microbiology laboratories that were only at The Royal Oldham Hospital carry out around 850,000 tests per year for the trust. The cellular pathology laboratories at The Royal Oldham Hospital carry out more than 41,000 histopathology tests for the trust, around 7000 non-gynaecological cytology tests and more than 180,000 cervical cytology tests (smear tests) per year. The cervical cytology tests included the Greater Manchester Cervical Screening Contract though this contract had recently been lost to Central Manchester NHS Foundation Trust.

Outpatient and diagnostic appointments are arranged by the booking and scheduling department. This centralised trust department is located at the Rochdale Infirmary. We visited this as part of our inspection and spoke to the senior manager who was the Interim Lead of Elective Access, the acting Cancer Services Manager, the Transformation Lead and the Head of Department.

We visited several outpatient clinics at The Royal Oldham Hospital in the main hospital building and the Lucy Pugh outpatients centre. We also visited the diagnostic imaging (Radiology) unit and pathology laboratories.

During the visit we spoke to 24 staff, including nurses, managers and clerical staff, doctors and radiographers. We also spoke to two patients. We reviewed four sets of medical records and observed direct care in clinics. We also held meetings for staff at the trust called focus groups that were attended by staff, including staff working in outpatient clinics and diagnostics.

Summary of findings

We rated outpatients and diagnostic imaging services Requires Improvement overall with the safe domain and the responsive domain requiring improvement and caring and well led as good.This was because:

- Staff were confident about raising incidents and encouraged to do so. The departments demonstrated that they applied the principles of duty of candour when things went wrong and that patients received an apology, full explanation and were supported going forward.
- The departments inspected were visibly clean and we observed staff following good practice guidance in relation to the control and prevention of infection. Equipment was clean and in good work order. Medicines were stored and checked appropriately.
- There were appropriate protocols for safeguarding vulnerable adults and children and staff were aware of their roles and responsibilities in regard to safeguarding.
- Staff in outpatients and diagnostic services demonstrated good team working (including multidisciplinary working) and were competent and well trained. Staff were up to date with mandatory training. There were low sickness absence rates. Staff felt respected and valued.
- Staffing levels were appropriate to meet patient needs although increased demand on the radiology services meant some reporting on diagnostic imaging was outsourced overnight to ensure that turnaround times for reports were within national guidelines. The department was actively recruiting to reduce staffing gaps and reduce the amount of work that it was necessary to outsource.
- Departmental managers were generally knowledgeable and supportive and had vision improve their services.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff who treated people with dignity and respect. Care was planned and delivered in a way that took patients' wishes into account. Their confidentiality and privacy were respected whenever possible.
- We saw instances of service planning and delivery to meet the needs of local people. The number of

Outpatients and diagnostic imaging

patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average. The cancer waiting times for the trust were consistently better than the England average.

- We saw good examples of assessing and responding to patient risk, such as the use of the World Health Organisation (WHO) checklist when performing procedures and policies for escalating unexpected findings. Reporting was triaged and risk-based.

However:

- The trust reported in their missed cancer diagnoses action plan that they had produced a leaflet and banners to support and empower patients, to ask about the tests they have undergone and that these had been distributed in all sites in outpatients and radiology. During the inspection, we were unable to find the leaflets in clinics and staff had not heard about them.
- The paper notes we reviewed contained limited information, were out of sequence and in some cases were illegible also not all notes had been scanned and paper notes were still in use for some patients..
- At November 2015 there was a staffing shortfall of 5.4wte Band 5 radiographers and 1wte Band 8a Manager. The department was actively recruiting 6 student radiographers
- In line with requirements, the radiology department should have had up to date sets of local rules that had been signed by staff and up to date radiation risk assessments. However, we found there was only one set of local rules and no risk assessments to hand. Although the risk assessments were shown to us online there was no indication that they had been printed off and signed by staff and that they were aware of, and had an understanding, of the rules and risks.
- Lucy Pugh Outpatients Department was located at the bottom of a very steep slope and was not safely accessible externally to those who were not steady on their feet or in the event of inclement weather. To enter the department internally via lift access involved a long walk through the hospital.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated this service as Requires Improvement for safe:

This was because:

- The trust reported in their missed cancer diagnoses action plan that they had produced a leaflet and banners to support and empower patients, to ask about the tests they have undergone and that these had been distributed in all sites in outpatients and radiology. During the inspection, we were unable to find the leaflets in clinics and staff had not heard about them.
- Four outpatient departments scored lower than the 85% pass rate on average in 2015 on environmental audit cleaning scores. We have seen no action plan to ensure that the pass rate was always met. There were some ongoing issues and challenges with the implementation and embedding of the new paper light electronic records system. Notes were not being scanned onto the new system on demand, in advance of outpatient appointments or elective treatment. As a result, there was still a mix of paper notes and electronic notes at clinics.
- The paper notes we reviewed contained limited information, were out of sequence and in some cases were illegible.
- At November 2015 there was a staffing shortfall of 5.4wte Band 5 radiographers and 1wte Band 8a Manager. The department was actively recruiting 6 student radiographers

However:

- Staff knew how to report incidents and were encouraged to do so. Investigations were undertaken in a timely manner and staff received feedback from incidents to encourage learning and reduce the reoccurrence. Staff followed the principles of Duty of Candour.
- All outpatients and diagnostics departments inspected were visibly clean and staff were observed following good practice guidance in relation to the control and prevention of infection.

- Medicines were stored and administered in line with best practice.
- A new electronic patient note system was being introduced which would minimise the risk of lost or missing notes. The World Health Organisation (WHO) risk assessment checklist was used in radiology to minimise patient risk.
- Staff had received safeguarding training and mandatory training was above target levels in all areas. Staff understood how to identify and escalate safeguarding concerns.
- There was appropriate signage to prevent patients from entering harmful areas and equipment had undergone appropriate maintenance checks.
- Nursing staffing levels were in line with planned numbers, there was a good staff skill mix and the trust had clear escalation procedures in place where safe staffing levels in clinics could not be established. There were few vacancies in pathology, except in Cytology. There were no staffing gaps at consultant level in outpatients.
- The trust had a major incident policy and this contained details about the suspension of outpatient clinics in the event of a major incident

Incidents

- There were no "Never Events" (very serious, wholly preventable patient safety incidents that should not occur if the preventative measures are in place) reported in outpatients and diagnostics in the 12 months before our inspection.
- There had been one Serious Incident Requiring Investigation (SIRI) reported from 1 November 2015 to 31 January 2016. These incidents require a root cause analysis investigation into the causes and must be reported on the NHS England Strategic Executive Information System (STEIS). The root cause analysis report was not available for us to review at the time of inspection as it had not been fully completed. From 1 January 2015 to 1 November 2015, there was one serious incident that involved outpatient letters for a patient being sent to an incorrect address because details had been entered incorrectly onto the Patient Administration System (PAS).
- The radiology unit has a duty to protect patients from radiation exposure under the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. The unit reported 11 exposure to radiation incidents from 1 December 2014 to 30 November 2015. 6 caused no harm to the patient; 3 caused low harm; 1 caused moderate harm and 1 incident was near miss.
- Another local NHS Trust audited radiation incidents. The radiation protection officer held a 1 to 1 with the staff member who had administered the radiation and they were expected to write a reflection on the incident to learn from the event.
- Staff knew how to report incidents and were encouraged to do so. They demonstrated that they knew to contact a manager if incidents needed immediate escalation. We were given an example of an incident that had happened that day where a clinic had been cancelled and then re-instated but the Band 7 was not told so staff had to be found to cover at short notice.
- The pathology labs had a zero-tolerance on incorrect sample labelling and any incorrect labels were reported as incidents.
- Lessons learned were discussed in the sisters' meeting that covered the four hospital sites. Incidents and investigation feedback was then cascaded at outpatient department team meetings that took place every other week.
- Outpatient departments in Royal Oldham Hospital reported 82 incidents in total during the period 1 December 2014 to 30 December 2015. The majority were risk assessed as "no harm" incidents This was indicative of a positive reporting culture. Three incidents were reported as moderate harm. Two of these were in relation to hospital acquired pressure ulcers that had been identified in outpatients on removal of plaster casts.
- In paediatric outpatients, 17 incidents were reported from December 2014 to December 2015. Most of these incidents were risk assessed as "no harm" incidents. Four open incidents had not been investigated. The Paediatric service had had an absence of two Governance roles for 4 months and there was a relatively new post holder at the time of our inspection. They had produced a report at the time of our inspection that showed a range of incidents that had not been investigated. The Matron was experiencing some challenges with staff at ward and departmental level who were responsible for reviewing and initially

investigating incidents. The four incidents in Paediatric Oupatients had not been reviewed. On our unannounced inspection, the Matron agreed to review the incidents immediately.

- The outpatients and diagnostic departments used an online incident reporting system that was linked to RIDDOR (Reporting Injuries, Diseases and Dangerous Occurrences in health and social care). This provided some assurance that incidents were being managed appropriately and reported to appropriate authorities.
- In the radiology department, incidents were reported if a clinic list was cancelled. If a more serious incident occurred, such as any bleeding from a covered stent or graft, it was recognised that an emergency could ensue and resuscitation actions were implemented. Oxygen and intravenous (IV) fluids were made available to patients. A Band 6 radiology nurse acted as a link nurse for resuscitation and was responsible for training other nurses in the department.
- The Health and Social Care Act 2008 Duty of Candour Regulation requires that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. A duty of candour policy was in place, staff were aware of their responsibilities to be open and honest with patients and followed the principles duty of candour.
- During 2015, the trust identified a number of incidents and complaints, indicating that systems for requesting, review, reporting and recording of diagnostic tests required review. This was particularly with regard to cancer diagnoses. In response, a review of 1635 incidents and complaints from the last five years was commissioned. The trust also developed a Diagnostics Improvement Group to oversee an improvement plan. The Quality and Performance Committee approved this plan. 181 of the incidents required a more in-depth review and, at the time of inspection, 159 of these had been completed. Of these, 18 cases were identified as probably preventable; 13 had strong evidence of preventability and 40 were definitely preventable. In addition, five cases did not meet the requirements for Duty of Candour. Refresher training had been given to staff on Duty of Candour following the review.
- Learning from the missed cancer diagnostic review identified that there was no standard approach or policy for requesting, review, reporting and recording of investigatory tests. There was a lack of systems and safety nets to ensure abnormal results were acted upon, including communications between the trust, the patient and GPs. There was a lack of ownership for following up tests and backlogs in reporting in radiology and administrative processes for patient letters. Knowledge-based, clerical and human errors were also contributory factors.
- The trust response to the review and the improvement plan was to provide additional resources to deal with patient letters within a 10-day timescale and at January 2016, they were above the 95% target. They had developed internal professional standards and a policy that was approved by the Safety Committee. They were developing an e-learning programme to advise staff on the correct procedures to be followed.
- The trust also reported they had produced a leaflet and banners to support and empower patients to ask about the tests they had undergone and that these had been distributed in all sites in outpatients and radiology. However, during the inspection, we were unable to find the leaflets in clinics and staff had not heard about them.

Cleanliness, infection control and hygiene

- All outpatients and diagnostics departments inspected were visibly clean and staff were observed following good practice guidance in relation to the control and prevention of infection.
- We saw that staff were bare below the elbow in clinical areas, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines on infection control.
- Hand gel dispensers were plentiful and well stocked in all departments and appropriately placed for use by patients and staff.
- Sharps waste boxes in outpatients and radiology were sealed to minimise infection control and were signed, and dated. They were not overfilled in line with best practice guidance.
- Hand hygiene audits, carried out on a monthly basis, scored an average of 95% compliance.
- In the Patient Led Assessments of the Care Environment (PLACE) audits for 2015 the outpatient areas scored 100% for cleanliness.

Outpatients and diagnostic imaging

- In radiology there was an Aseptic Non Touch Technique (ANTT) link nurse who carried out hand hygiene training and audits.
- In outpatients, a trolley mattress audit took place every three months to ensure that mattresses remained fir for purpose, safe for patients and were changed where necessary. They also took part in medicines storage audits, health and safety audits and hospital acquired infection audits on a monthly basis.
- In radiology, if a patient with a communicable disease presented, level 3 personal protective equipment (PPE) was used and a deep clean of the treatment room took place following a procedure.
- Staff received mandatory training in infection control and were aware of where to find the infection control policy.
- The pathology labs at Royal Oldham Hospital were visibly very clean. Staff understood their roles in hygiene, health and safety and infection control was ingrained. Staff wore personal protective equipment at all times in the laboratory setting.

Environment and equipment

- The Electro-Biomedical Engineering Department (EBME) was responsible for the maintenance, repair and management of medical equipment. All high risk medical equipment was scheduled for planned preventative maintenance. At the time of our inspection, an inventory of missing equipment was being written and audited. The hospital was carrying out a rolling programme of checking all medium risk equipment for safe operation and labelling low risk equipment as “not for maintenance”.
- The hospital kept a schedule of all x-ray and scanning equipment that showed the date the contract was due to be renewed and identified any equipment that had been decommissioned. The schedule was up to date and highlighted forthcoming contract renewals clearly in red.
- Environmental audit cleaning scores in outpatients and diagnostic clinics had a pass rate of 85%. In 2015 the average percentage scores ranged between 79.1% in outpatients to 87.9% in x-ray. Four outpatient departments scored lower than the 85% pass rate, on average, in 2015. We have seen no action plan to ensure that the pass rate is always met.
- In the PLACE audits for 2015 the outpatient areas scored 100% for condition, appearance and maintenance.
- Resuscitation trolleys were located in outpatient and diagnostic departments. They were clean and in good order with all the required equipment available. Records showed the trollies were checked on a daily basis.
- The main outpatient departments and radiology were accessible in the main hospital at ground floor level when entering at the front. They were light, airy, and visibly clean. Other outpatient clinics were located in different parts of the hospital. The Diabetes Centre was located in a pre-fabricated building on the lower part of the site, away from other buildings. Nurses who were based there told us they were forced to work in corridors because of a lack of clinical space in the building. The Lucy Pugh Outpatients Department was located at the bottom of a very steep slope and was not safely accessible externally to those who were not steady on their feet or in the event of inclement weather. To enter the department internally via lift access involved a long walk through the hospital.
- The Royal College of Nursing had noted that, at the Royal Oldham Lower Site (where some outpatients clinics were located), there was a lack of pavements, which was a safety concern.
- Staff told us that the long-term plan was to have all outpatient departments under one roof and on one level. However, we do not know when any planned work was due to start.
- In radiology, contrast agent was kept in a locked cabinet. We saw some in a warming cabinet but this was not accessible to general staff and showed good practice.
- Clinical waste was correctly disposed of in radiology using orange bags with a zip lock system. The bags were labelled.
- There were appropriate warning signs on doors in radiology with restricted access to areas where there was radiation or high power lasers.
- The hospital had a policy, procedures and protocols in place in relation to the Ionising Radiation (Medical Exposure) Regulations [IR(ME)R].
- The hospital had radiation protection supervisors in place to ensure radiological protection requirements were met and they produced annual reports. They were supported by a radiation safety group that met quarterly and produced an annual report.
- In line with requirements, the radiology department should have had up to date sets of local rules that had been signed by staff and up to date radiation risk

assessments. However, we found there was only one set of local rules and no risk assessments to hand. Although the risk assessments were shown to us online there was no indication that they had been printed off and signed by staff and that they were aware of, and had an understanding, of the rules and risks. The Departmental Manager did not seem to be aware of the requirements.
- The trust used a system that automated many of the processes in requesting diagnostic testing. Patient demographics and barcodes were produced by the system for attachment to specimen tubes and clinicians could review the progress of outstanding patient requests. As a result, errors in incorrectly labelling specimens were reduced.
- The pathology services were accredited with UKAS (United Kingdom Accreditation Service) who inspect and accredit the laboratories and ensure that they are operating safely.

Medicines

- Drug fridges in each department were locked, temperatures were recorded daily and found to be in the recommended range.
- A check on the controlled drugs that were kept in the radiology department (four opioid drugs) found that stocks were recorded accurately, were appropriately stored, sealed and in date. There were no controlled drugs used in Outpatients.
- In Outpatients A, drugs cupboards were in a locked room and were shared with the out of hours GP service. Pharmacy carried out and maintained a weekly stock check. A check on drugs and dressings showed that all were in date.

Records

- The trust had started to use an electronic paper light system and the process of scanning existing health records onto the system was ongoing. We looked at the electronic patient record system and notes were scanned so that the system could filter out the notes from different hospital departments and medical episodes. A barcode sticker, which is a unique identifier, was used to link the notes to the correct record when scanned and was added to all new handwritten notes or forms.
- However, notes were not being scanned on demand, in advance of outpatient appointments or elective treatment. As a result, there was still a mix of paper notes and electronic notes at clinics.
- A pilot of the system showed there was an improvement in the quality of information recorded; updating information in a timely manner; ease of reviewing the patient's journey; ease of locating required information and ease of identifying who had made previous entries.
- Factors had been considered in the rollout of the new system, including whether the electronic records were easily readable to staff with dyslexia or similar conditions.
- Where notes were not present the Automated Letter System (ALS) was used so that referral letters and diagnostic results (where possible) were present. Clinics should have been able to track down the notes on the patient administration system (PAS) tracker system but there was an ongoing communication issue with the health records ream. They were not reporting to a manager that notes were not present. This resulted in missing notes being reported as incidents by outpatient staff.
- Statistics on the percentage of notes missing in clinics was not available as the incidents were generally recorded as "clinical issue" and could not be readily extracted.
- An audit undertaken by the trust showed that, between October 2014 and September 2015, records were available 99.8% of the time at the time of clinical care. This met the 99% standard.
- We looked at two sets of patients notes in Outpatients A on the electronic "paper-light" system and compared this with a paper record. The paper light file contained only the information that was required for that particular clinic and the notes were legible. The paper notes file appeared to contain nothing about the appointment in the outpatients clinic. Other notes on the file were out of order and some were illegible.

Safeguarding

- In radiology, staff at Band 6 and above had completed level 3 safeguarding training and staff below Band 6 were trained to level 2. This included child safeguarding.
- Staff in outpatients were all trained at Level 1 in safeguarding with the Band 6 and 7 Nurses trained at Level 2. There were no plans to raise the level of training.

- Staff were aware of the process for reporting suspected safeguarding incidents or abuse and examples were given of concerns raised possible domestic violence and injuries sustained in a care home.
- Staff in radiology were aware of female genital mutilation (FGM) and would report this as a safeguarding concern. Although they could not give an example of where FGM had been suspected they were aware that it may be identified through skeletal x-rays on female children or when conducting a hysterosalpingogram (fallopian tubes and uterus x-ray procedure). Staff in outpatients were also aware of FGM and this was included on the safeguarding report form.
- The Patient Administration System (PAS) had a facility to flag safeguarding alerts. We were shown this facility on the system. Staff were able to demonstrate their knowledge of the system and it meant that if there was a safeguarding concern over a patient, this would be highlighted and had to e acknowledged as soon as the patient's records were accessed.

Mandatory training

- Staff received mandatory training in a range of subjects including manual handling, infection control and conflict resultion. Mandatory training completion rates amongst staff in outpatients was at 98%, which was above the trust's 95% target. Mandatory training completion in radiology was at 99% compliance.
- Staff were notified of training due on a weekly basis by the Band 6 nurse with time allocated to complete.
- Training was delivered by e-learning or face to face though the Manager told us that conflict resolution and tissue viability courses were only run two to three times per year so it was not always possible to do the training in a timely way.
- Staff in outpatients were trained in basic life support skills.
- In paediatric outpatients, 100% of nursing staff and additional clinical service staff were up to date with their essential job-related training.

Assessing and responding to patient risk

- The radiology unit was using the WHO checklist. The WHO Checklist identifies three phases of a procedure, each corresponding to a specific period in the normal flow of work: Before the induction of anaesthesia or other drugs ("Sign In"); before the commencement of the procedure ("Time Out") and before the patient leaves the procedure room ("Sign Out"). In each phase, a checklist co-ordinator must confirm that the team has completed the listed tasks before it proceeds with the procedure. It is designed to minimise patient risk and avoidable harm whilst undergoing a procedure.
- Radiology staff held an interventional meeting in the morning and this linked to the WHO checklist. For patients having interventional procedures they held a "WHO huddle". As patients came in they went through the initial WHO checklist, the "Sign In". Just before the procedure took place, staff would read out and agree the "Time Out" part of the checklist and then they would use the "Sign Out" checklist at the end of the procedure to ensure that everything was accounted for. Procedures were discussed at the end of the day at a further WHO meeting.
- The checklists had been refined to improve them and meet best practice. The checklist ensured that patients who may be at higher risk were identified by asking questions regarding smoking, asthma and diabetes, for example.
- An audit carried out in 2015 determined that the interventional radiology rooms were 93% compliant in completing the WHO checklist.
- In radiology, patients who had undergone an interventional procedure underwent observations for a minimum of 30 minutes after the procedure to look for any signs of complications or deterioration. A handover meeting took place with a nurse for any inpatients who were returned to the wards.
- The trust used a sheet for female patients of child-bearing age in the radiology department to ask them about their last menstrual period and risk that they may be pregnant. This was to minimise the risk of a woman who may be pregnant being exposed to radiation. In cases of doubt, a pregnancy test was undertaken.
- To reduce reporting times and therefore, the risk to patients, CT scans were outsourced to reporting radiographers in Australia overnight from 8pm, using a "follow the sun" model. Follow-the-sun is a type of global work flow in which tasks are passed around daily between work sites that are many time zones apart. Such a workflow is set up in order to reduce project duration and increase responsiveness so CT scans could be reported on 24 hours a day.

Outpatients and diagnostic imaging

- In pathology laboratories there was good exceptional reporting with unexpected results telephoned through to the request initiator immediately.
- In haemoglobin testing, staff looked for lifelong anaemias such as sickle cell and thalassaemia majors. If either were suspected a second sample was requested for further testing and a coded comment was given to the clinicians to suggest further testing for these conditions as patients are supposed to be counselled if these conditions are being tested for.
- In antenatal blood screening, all abnormal results were stored on a spreadsheet with coded comments if sickle cell was suspected, and the antenatal department was called. Midwives chased up the results. An "at risk" couple would be referred to the sickle cell service. The lab received around 160 abnormal antenatal results per year.

Nursing staffing

- The trust had clear procedures on escalation where safe staffing levels in clinics could not be established.
- Nurse staffing allocation in the main outpatient department clinics was planned against those clinics that were scheduled. It was variable on a session by session and week by week basis due to varying templates, cancelled clinics and additional clinics scheduled.
- The electronic rostering system was unable to capture the staffing requirements on a daily basis (as it could for inpatient wards) and there was therefore no facility to extract planned versus actual data.
- The trust took the view that the role of a registered nurse in clinics was to ensure the smooth facilitation and co-ordination of the clinic, especially where there were large numbers of patients who required diagnostic tests prior to their consultation. They used Band 5 nurses in certain clinics where additional knowledge and skills were required and there was no specialist nurse input. Registered nurses also had responsibility for the supervision of student nurses.
- The number of nurses and required grades were assessed based on the complexity, type and location of the clinics. The trust had banded each type of clinic and established the minimum nursing levels. For complex clinics a registered nurse was always required; Interventional clinics required a registered nurse most of the time due to intervention procedures; Geographic/ Supervisory clinics required a registered nurse due to the location (e.g. it was in a remote building) or supervisory requirements and Non-Interventional clinics did not require a registered nurse though supervision was made available.
- The trust supplied details of how each type of clinic was graded; for example, breast clinics were graded as complex, requiring a Band 5 Nurse to support surgical interventions, administer complex dressings; deliver 1:1 care and support patients who are given bad news.
- There was a good skill mix of staff with Band 3 nurses being able to assist with wound care. Some clinics were led by specialist nurses though they were part of different directorates, for example, the colorectal clinic. This clinic did not fund for additional outpatient nurses.
- Outpatients had 40 whole time equivalent (WTE) nursing and health care assistant (HCA) staff. At the time of inspection, there were 2 staff on long-term sick leave. The staff were managed by one Band 6 and one Band 7 nurse. The greatest number of staff were Band 5 nurses (11 WTE) and Band 2 HCAs (11.8 FTE).
- Staff turnover overall was stable. The trust were recruiting four Band 2 part-time HCA staff in March to fill vacancies. Some Band 2 staff had left to become nurses.
- The phlebotomy team had a vacancy gap for two full-time Band 2 HCAs. The trust had recruited to fill one post but they were unable to act as a phlebotomist until they had undergone appropriate training. Two bank staff were currently covering the vacancies. Bank staff were also covering one Band 5 nurse vacancy and one plaster technician who was on long-term sick leave.

Allied Health Professionals

- Radiology had undergone a staffing restructure in 2013 and in January 2014 there were eight staff vacancies. At November 2015 there was a staffing shortfall of 5.4WTE Band 5 radiographers and 1 Band 8a manager.
- At November 2015, there were 47.4WTE radiology staff in post against an establishment of 53.8WTE.
- At the time of our inspection, the department was actively recruiting 6 student radiographers.
- Staff reported that there was a good skill mix in the department, having established the role of assistant practitioner and there was little use of bank and agency staff. Vacant posts were advertised promptly.
- Staff rotated between different skills within the department.

Pathology

Outpatients and diagnostic imaging

- There were few vacancies in the pathology labs, in general, except in cytology. The cytology department was carrying vacancies that they could not fill because of the loss of the gynaecology cytology contract to another trust. In addition, three staff were off long-term sick and they had been unable to get locum support. Existing staff were carrying out overtime to get the work done and minimise the backlog.
- The biochemistry lab ran for 24 hours a day, 7 days a week. A number of staff worked late shifts with two overnight staff in haematology and one in biochemistry.
- Microbiology had 88 staff. They had a full complement of consultant microbiologists. There was an on call service at night with one biomedical scientist on duty. The department was interviewing for 2 posts at Band 4 during the week of inspection and for two Band 6 posts the following week. There were also some vacancies at support worker grade. Support workers prepared the samples for scientists to examine the following day. Band 4 practitioners prepared culture plates for positive cultures and this made the work less labour-intensive for Band 6 biomedical scientists.
- The microbiology services manager was on a 7-week on call rota for out-of-hours. This meant that for one day a week (Monday, then Tuesday etc.) they would be responsible for the whole hospital site between 5pm and around 10pm and would need to deal with any staffing problems or other issues such as a staff member not turning up for work in A&E. Following the seven-week rota there was a period of eight weeks off. The manager told us that the rota system made the managers work better as a team across the site and understand clinician pressures. The morning after an on-call shift, the manager only undertook administration tasks to minimise the risk of clinical errors.

Medical staffing

- Consultant radiology cover was provided on site from Monday to Friday 9am to 5pm.
- A general on-call radiology service was provided on weekday evenings from 5pm to 9pm by a trust-wide rota supported by trust consultants. From 9pm to 9am general on-call services were provided by a contracted reporting radiologist seven days a week. A consultant provided on-call services at weekends from 9am to 9pm.
- Interventional radiology was provided Monday to Friday 9am to 5pm. Out of hours the service was provided by a trust-wide rota from 5pm to 9am on weekdays and 9am to 9am on Saturdays and Sundays.
- Vacancies for radiologists across the trust were noted on the risk register and speciality trainees were encouraged to apply for vacant posts.
- Consultants criticised the induction for locums who were "just given a manual of things they should know". They also said there was often a problem with timely access to IT systems for new locums.
- There were no gaps at consultant level in outpatients. Where clinics were cancelled or delayed due to no consultants being available, this was generally because they were delayed in surgery, often at another location.

Major incident awareness and training

- The trust had a major incident policy and this contained details about the management/suspension of outpatient clinics in the event of a major incident. We were told by a Manager that actions in the event of a major incident had been discussed at team meetings.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

- The pathology services had invested heavily in technology and equipment to enhance the delivery of effective care and treatment.
- Staff were aware of the National Institute for Health and Care Excellence (NICE) and policies based on NICE guidelines were in use in outpatient and radiology departments.
- All staff were involved in "raising the bar on quality" where ten key action points had been introduced to make the trust and its services the best it could be for staff and patients.
- The workload and turnaround times in laboratories was monitored to maximise patient outcomes.

Outpatients and diagnostic imaging

- The audiology teams for adult and paediatric audiology were participating in the improving quality for physiological services accreditation scheme.
- Staff development and further education was encouraged within the services. Staff had received appraisals and 1:1s.
- Electronic systems used by pathology enabled results to be obtained by Consultants and GPs. The system had significantly improved the quality and speed of test request and results between primary and secondary care settings.
- The follow-up to new rates rate for appointments was lower than the England average since August 2014.
- Some services ran 7 days a week, 24 hours a day. Running other services on weekends was being considered according to demand.
- There was good multidisciplinary working between services.
- Consent forms were audited and showed good levels of compliance. Best interest meetings were held appropriately where patients lacked capacity to provide informed consent.

However:

- However, no paediatric staff were up to date with their appraisals in outpatients and no nurses in paediatric outpatients had Advanced Paediatric Life Support (APLS) training. This was escalated to the trust for immediate action.
- The reception staff, who worked under the elective access directorate had not received appraisals.
- Not all referral to treatment times for each type of clinic was available on the NHS Choices website.

Evidence-based care and treatment

- The pathology services had invested heavily in technology and equipment to enhance the delivery of effective care and treatment. For example, the biochemistry lab had an automated haematology system for analysing bloods that could analyse up to 800 tubes per hour and provided automatic sample validation.
- In the microbiology labs, boric acid containers for urine cultures maintained the microbiological quality of the specimen and prevented overgrowth of organisms during transport to the lab. The department also had brand new blood culture machines though these were still in the verification phase at the time of inspection. There was a MALDI (Matrix-Assisted Laser Desorption/ Ionisation) in the lab that could identify bacteria in minutes using lasers, rather than a number of days growing cultures.
- The cellular pathology lab had recently acquired a microwave tissue processor that was undergoing the validation process at the time of inspection.
- Staff were aware of the National Institute for Health and Care Excellence (NICE) and policies based on NICE guidelines were in use in outpatient and radiology departments.
- The trust had an action plan around misdiagnosis of cancers and this included the development of a trust wide policy incorporating NICE guidelines and the National Patient Safety Agency 16 guidelines. At the time of our inspection, work on this was still ongoing . New standard operating procedures were also in development.

Nutrition and hydration

- Drinking fountains were available to patients in outpatients and radiology departments.
- Diabetic patients requiring food whilst waiting in radiology were offered it.

Pain relief

- Analgesia and topical anaesthetics were available to children who required them in the outpatients department.
- Patients requiring pain relief whilst in clinic would bring their own medication that was reviewed by medical staff, as appropriate.
- Opioid drugs, such as Fentanyl; Oramorph and Midazolam were available for pain relief in radiology for those patients who had undergone interventional procedures.

Patient outcomes

- The follow-up to new rates for clinic attendances across the trust as a whole was in the mid to low quartile when compared to other trusts. At The Royal Oldham Hospital the rate was lower than the England average since August 2014.
- The pathology department was undertaking an audit on physicians checking results in a timely way, using the available electronic systems.

Outpatients and diagnostic imaging

- The workload and turnaround times in laboratories was monitored to maximise patient outcomes.
- The pathology Services were accredited with UKAS (United Kingdom Accreditation Service).
- The audiology teams for adult and paediatric audiology were participating in the improving quality for physiological services accreditation scheme. It consisted of meeting criteria in four domains of service provision namely: patient experience; facilities; resources and workforce and safety and clinical. The departments were intending to submit for accreditation by the end of June 2016.
- Quality and performance were monitored in outpatients through a dashboard. This covered data such as sickness rates, new complaints, RTT rates, bed occupancy figures and additional information, such as appointment cancellations and DNA (did not attend) rates.
- New appointments accounted for 33% of appointments whilst 57% were follow-up appointments. This was in line with expected ratios and was aligned to other sites in the trust.
- 10% of patients did not attend (DNA) their appointments. Figures for patient and hospital cancellation of outpatient appointments were not recorded separately. Managers were not aware of any action plans to improve this, for example, sending reminder texts to patients. Further appointment letters were sent or the patient was referred back to their GP if they failed to attend more than once.
- All staff were involved in "raising the bar on quality" where ten key action points had been introduced to make the trust and its services the best it could be for staff and patients.

Competent staff

- Healthcare assistants in outpatient clinics were able to undertake a national vocational qualification (NVQ) which in turn enabled them to carry out venepuncture and physiological measurements. Two staff were currently undertaking an NVQ level 2.
- The hospital was supportive of staff undertaking further education and training and staff were encouraged to undertake further training in areas of interest. There were a number of link nurses in each department who had been given enhanced training in specialisms and were able to train other staff accordingly and give advice where necessary. They trained staff in any new procedures or equipment, for example, the use of new types of dressings.
- The needs of people living with dementia were considered in planning care and treatment. Staff undertook an online dementia training course and there was a dementia link nurse to offer more expert advice.
- The pathology unit was a training base for the region and had a working relationship with Manchester Metropolitan University who provided some funding. The service often employed people they had trained.
- Staff had regular 1:1's with the band 6 Nurse in outpatients and were confident to raise any issues as they arose.
- In adult outpatient clinics all staff had received an appraisal within the last 12 months with one staff member due to have an appraisal imminently. This had been identified and was scheduled in.
- However, no paediatric staff were up to date with their appraisals in outpatients.
- No nurses in paediatric outpatients had Advanced Paediatric Life Support training. This was escalated to the trust for immediate action.
- Staff in radiology attended quality and performance meetings quarterly.This raised staff awareness and aided future learning. The meetings had a set agenda with standing iems and covered incident reviews, key risks, performance monitoring, complaints and patient deaths.
- All staff in radiology had received an appraisal in the last 12 months.
- Staff in radiology attended medical device training to maintain their skills and competence in using medical equipment.
- There were clinical tutors available to radiography students and the trust worked closely with local universities in student training.
- We spoke to a receptionist in the radiology department who had not had an appraisal for around two years and did not have one booked. They reported that they used to work under the radiology department and had appraisals but now worked under elective access where appraisals had not been undertaken.

Multidisciplinary working

Outpatients and diagnostic imaging

- The microbiology team in pathology services worked closely with link nurses in the hospital who were knowledgeable in infection and prevention control and helped in ensuring that appropriate blood cultures were examined.
- Where a result of "Skinflow significance doubtful" was found in microbiology, this was conveyed to the clinicians in real time.
- If a particular doctor was sending through culture samples that showed high contamination rates, this was raised with the consultant at the earliest opportunity.
- The haematology team worked closely with clinicians where lifelong anaemias such as sickle cell or thalassaemia majors were suspected to enable the patients to be offered counselling at the earliest opportunity.
- There was an efficient collection and delivery service of pathology samples between all the sites with samples being delivered throughout the day.
- There was evidence of good multidisciplinary team working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked as a team.
- The radiology department ensured that it met clinical guidance for turnaround times for diagnostic imaging reports by outsourcing work overnight to private companies or individuals though this placed financial pressures on the department.
- The electronic patient records system allowed clinicians to access other pathways that the patient may be on which allowed ongoing care to be co-ordinated and communication between different teams.
- Staff in outpatient clinics worked closely with podiatrists, the vascular team, physiotherapists, orthotics and Macmillan nurses.
- The breast clinic had established excellent multidisciplinary working with cellular pathology. Patients saw the nurses and consultants, had a biopsy and the results were available by 4pm the same day.
- Patients at the vascular clinic were able to see the consultant, go for their vascular procedures and go straight back to see the consultant. Physicians from the local specialist cancer hospital supported the service.
- In adult medicine, patients in the Doppler clinic were able to go for an ECG and then return to the consultant for the outcomes on the same day.

Seven-day services

- Some outpatient clinics were arranged on evenings or Saturdays but these were ad hoc and addressed waiting list backlogs. In general, outpatient clinics only ran mainly on week days only.
- X-rays and CT scans were available 7 days a week for inpatients. There was a radiologist on-call at night in the department. Interventional radiology was available trust wide after 5pm and at weekends.
- Paediatric outpatient appointments were only available from Monday to Friday.
- The biochemistry laboratory in pathology services ran 24 hours, 7 days a week with a number of staff on the late shift and two overnight staff in haematology and one in biochemistry.
- The microbiology lab was undergoing a study on whether the service needed to be provided on a 24/7 basis at the time of inspection though they did not have enough technical staff to process cultures at night. There was an on-call service at night with one biomedical scientist on call from an on-call room or home.
- There was no weekend service in the cellular pathology labs because biopsies in the hospital sites were generally collected only on weekdays. However, when the endoscopy department occasionally ran a Saturday service to reduce backlogs, this could result in the histology lab starting on a Monday with 50-60 biopsies to examine.

Access to information

- The trust used a system that automated many of the processes in requesting diagnostic testing. Clinicians in the trust and in 160 local GP practices could review the progress of outstanding patient requests and reports without having to wait on paper-based results. The system had significantly improved the quality and speed of test request and results between primary and secondary care settings.
- The trust also used an electronic system to disseminate pathology, radiology and clinical correspondence documentation to its GP community. Clinicians could view test results from other care settings, allowing them to read test results in context, to better evaluate treatment choices. Discharge summaries were also available on the system.
- Cellular pathologists used a software based digital dictation system to dictate their reports that were then

typed by medical secretaries. Samples were photographed and photos were embedded in the reports meaning that the recipient of the report could visualise what was being described in the report.
- An electronic ordering system was shortly to be rolled out across outpatients, diagnostics and pathology departments that enabled the electronic ordering of diagnostic tests and results reporting. It also enabled clinicians to log in to a number of different systems at one time so it integrated with the electronic health records system. The system would be available 24 hours a day so would significantly reduce requesting and reporting times.
- Consultants were issued with hand-held electronic devices that could access the electronic patient records system.
- The electronic patient record system held full historic patient notes. They had been scanned such that details of relevant medical conditions could be filtered out and were easily accessible to the clinicians.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent forms were available in all clinics. Some patients consented to treatment whilst in clinic but the majority of patients signed consent forms at the pre-operative stage of their treatment.
- TheMental Capacity Act(MCA) is in place to protect and empower individuals who may lack themental capacityto make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. The Deprivation of Liberty Safeguards (DoLS) aim to protect people who lack mental capacity, but who need to be deprived of liberty so they can be given care and treatment in a hospital or care home. Training on DoLS was available to all staff in outpatients and MCA training was part of mandatory training as part of the level 2 safeguarding course.
- Outpatients staff reported few issues with mental health and mental capacity. Staff were able to escalate concerns when they were unsure about the capacity of a patient to make an informed decision and contacted someone from the safeguarding team for advice. Patients under the care of a mental health trust had their own outpatients department as part of that trust.
- In outpatients consultants held multidisciplinary best interest meetings to decide the best course of treatment, where the patient lacked capacity. Best interest meetings also took place between the radiologists and the referring team if the patient lacked mental capacity.
- Consent forms in radiology were audited. A recent audit showed that forms were legible, signed and dated correctly with the status of the practitioner. Risk assessments were correct and consistent.

Are outpatient and diagnostic imaging services caring?

Good

We rated this serviceas good for caring because:

- Kind, caring and compassionate staff delivered outpatient and diagnostic services in The Royal Oldham Hospital. They were observed to be polite, friendly, helpful, and made efforts to alleviate patient fears.
- Staff were encouraged to “think compassion” in every action and interaction and to be approachable and respectful. This was from “Raising the Bar on Quality” that was being implemented across the trust.
- Friends and Family Tests (FFT) carried out in the period December 2015 to February 2016 showed a 99% positive response.
- The hospital had a number of clinical nurse specialists who were knowledgeable and available for patients and relatives to discuss their condition.
- In the Patient Led assessment of the Care Environment (PLACE) assessments for privacy, dignity and wellbeing, the hospital scored higher than the England average in the Lucy Pugh Outpatients Department.
- There were staff in the breast care and other clinics who had received advanced training in breaking bad news and supporting patients.
- Staff used information leaflets and letters to explain what patients could expect during their care and treatment.

However:

- In the PLACE assessments for privacy, dignity and wellbeing, the hospital scored lower than the England average in Outpatients A.

- Staff in radiology reported that if patients needed to go to the toilet at the other end of the corridor, they would often have to walk down the corridor in gowns that were open at the back and this did not maintain their dignity.

Compassionate care

- Staff were encouraged to "think compassion" in every action and interaction and to be approachable and respectful. This was from "Raising the Bar on Quality" that was being implemented across the trust.
- Patients that we spoke to said that staff were helpful and kind and introduced themselves. They also reported that confidentiality was maintained.
- We observed that staff were friendly and supportive and reception staff were knowledgeable and able to help patients with queries other than about their outpatient appointment.
- All consultations and examinations took place in a closed examination room. There was appropriate signage on doors to indicate where a room was in use.
- We observed that reception desks in outpatient clinics were not always located far enough from seating areas to maintain patient confidentiality and privacy. We were told about an incident that had been reported where a patient did not wish to answer questions at the desk due to a lack of privacy. The outpatient manager was aware of the issue with reception desks and solutions were being sought.
- In radiology we observed that single sex changing rooms were available to maintain patient dignity. However, staff reported that if patients needed to go to the toilet at the other end of the corridor, they would often have to walk down the corridor in gowns that were open at the back and this did not maintain their dignity.
- The hospital had a chaperone service and patients with carers were encouraged to bring their carer to appointments. Nurses acted as chaperones during patient examinations when requested by a consultant or patient. The nurses gave reassurance to patients.
- Friends and Family Tests (FFT) carried out in the period December 2015 to February 2016 showed a 99% positive response. FFT survey results were collected and collated manually. There was no other electronic patient survey system in place.
- Outpatients had introduced a new patient survey and there was a box for responses at reception desks. The survey had not been in place for long and responses had not been collated at the time of inspection. The trust reported that they had carried out no other local patient surveys recently.
- The radiology department carried out patient quality surveys post experience. A recent quality survey had been carried out at the time of inspection, the results were being collated at the time and it had not yet been published.
- In the PLACE assessments, the hospital scored 93.9% in the Lucy Pugh Outpatients Department and 66.7% in Outpatients A for privacy, dignity and wellbeing. The national average score was 86%.

Understanding and involvement of patients and those close to them

- Patients that we spoke to told us that their doctor always explained their condition and treatment to them.
- Staff used information leaflets and letters to explain what patients could expect during their care and treatment.
- Patients were only given a copy of the letter sent to their GP by the clinic if they requested this at reception. Receptionists were supposed to ask patients if they would like a copy of the letter. We did not see whether this happened.
- In radiology we looked at appointment letters that clearly explained to patients the procedures they would undergo and what to expect.

Emotional support

- Breast care specialist nurses had undertaken the advanced communication skills training and were able to give emotional support when breaking bad news to patients.
- There were staff available in outpatient clinics who had also received training so they could break bad news to patients and offer emotional support.
- Patients we spoke to told us that they had adequate emotional support and would know who to contact if they were worried about their treatment or condition.
- The hospital had a number of specialist nurses in the clinics who were able to talk to and advise patients on their diagnosis and condition.

Are outpatient and diagnostic imaging services responsive?

Outpatients and diagnostic imaging

Good

We rated this service as Good for responsive because:

- Service planning of clinics met the needs of the local people. There was some flexibility in clinic times and numbers in response to waiting lists.
- The trust had two X-ray rooms located in Oldham town centre which were more convenient for non-trauma patients to attend and alleviated pressure on the hospital department.
- In the pathology services, specimen identification and flow was well-managed.
- Services had systems in place to meet people's individual needs, such as leaflets and videos in different languages; interpreting services; braille and large text services; British Sign language services; bariatric equipment and services for people with learning disabilities or who were living with dementia.
- The majority of complaints were handled in line with trust policy and were resolved locally wherever possible. Learning from complaints took place.

However:

- The percentage of people waiting more than six weeks for a diagnostic test had been worse than the England average since July 2015.
- The numbers of patients failing to attend their appointments was worse than the England average and there were no clear plans in place to improve this situation.
- We found instances where complaints were not responded to within the expected timelines and there appeared to be a need to embed the recently renewed policy, clear complaint backlogs and fill staffing vacancies on the complaints team.
- Though it was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average and the cancer waiting times for the trust were consistently better than the England average, we have subsequently learned that data collection in the department is not reliable and are not assured that targets are truly at that level. Work is being undertaken with the trust to clarify the current position.

- **Service planning and delivery to meet the needs of local people**
- The trust was working with commissioners to roll out new anti-coagulant drugs that do not require regular blood tests, meaning patients would not have to attend the hospital as frequently.
- Podiatry services for people living with diabetes were available Monday to Friday from at least one of the four hospital sites.
- Oldham Integrated Care Centre had two general x-ray rooms where non-trauma patients referred by GPs could attend. This was located in Oldham town centre. The service alleviated the pressure on the hospital and was in a more convenient location for patients. The service carried out around 140 x-rays per day.
- Referrals from GPs for x-rays at the hospital were for trauma patients only. It was reported by the manager that the service was busy and that sometimes patients had to stand in the waiting area.
- ENT and Orthopaedics clinics had separate play areas for children with wooden play toys that were cleanable.
- There was a room in the phlebotomy clinic for children and the trust was undergoing some health and safety checks to see whether they could have bubbles in the room for them.
- Car parking for patients and visitors at the trust had improved since designated staff car parking had been introduced.
- Outpatients and radiology departments within the hospital were clearly signposted though there were issues with people with reduced mobility in reaching the Lucy Pugh Outpatients Department via the quickest route.
- The dermatology service had been lost to another local NHS trust and patients in the Oldham area had to travel to the Tameside area to receive treatment.
- All GP and day-to-day pathology work for the trust went through the Oldham laboratories that were housed in a 3-storey building on site. The building had been commissioned in 2007 and over £17 million had been invested in the services provided. There were haematology and biochemistry laboratories at Fairfield and North Manchester General Hospitals but these were essential use laboratories.
- The NHS Choices website holds up to date information on referral to treatment (RTT) times for some, but not

all, department in outpatients and diagnostics, details the type of clinics held in each department, and enables patients to make an informed choice about their care and treatment.
- There were numerous patient information leaflets available on the trust website.
- The radiology department included fact sheets about the type of treatment a patient was to undergo in the appointment letters. The letters were sent from the central booking centre at Rochdale Infirmary. There were no information leaflets available to patients within the department itself.
- Outpatients departments had a wide range of patient information leaflets and were available in racks in the relevant clinics. However, the racks were such that the leaflet titles could not be read so it was not easy for a patient to find the appropriate leaflet quickly.

Access and flow

- In the pathology services, specimen identification and flow was well-managed. Samples were collected and delivered on an hourly basis from collection points across all the hospital sites and were sorted immediately upon arrival at the pathology reception.
- More urgent samples, such as those for patients in A&E were easily identified and prioritised. In cellular pathology, suspected cancers were dealt with first and the samples were on red slides for ease of identification.
- Urgent abnormal blood results were phoned through to clinics to speed up waiting times.
- Patients were given appropriate follow-up appointments based on when their test results could be expected. Results could be expected back in no longer than six weeks. Where results were expected within two weeks, the patient was given a further appointment in two weeks.
- There was a one-stop-shop for breast tissue screening with results being available on the day of screening by 4pm. Patients were able to return for their results later in the day.
- At the time of inspection, there was an influx of smear tests and we were told that this happened every year, nationally, at around the same time and was known as the "Jade Goody effect". The trust had been in touch with the CCG to seek solutions but other local hospitals were experiencing similar work influxes.
- Though it was reported that the numbers of patients waiting longer than 18 weeks from referral to treatment (RTT) was consistently better than the England average.and the cancer waiting times for the trust were consistently better than the England average, we have subsequently learned that data collection in the department is not reliable and are not assured that targets are truly at that level.Work is being undertaken with the trust to clarify the current position.
- There was a central booking centre for all outpatient appointments and this was based in Rochdale. The staff worked in speciality/pathway teams with a co-ordinator tracker to track referral to treatment times (RTT) for their speciality. The teams met weekly and the pathway co-ordinator fed back any problems with RTT to the clinical teams. The process engaged with clinicians as trackers attended directorate meetings. The tracker would inform clinicians of the impact of clinic cancellations or delayed appointments.
- The trust had monthly referral to treatment (RTT) meetings and action plans were in place to improve the RTT times in a number of specialities.
- Trust policy was that only a directorate manager could cancel clinics. Where clinics needed to be cancelled at short notice, staff would try to contact patients by phone or letters would be sent by taxi. Clinic cancellations were minimal and the cause was generally because a consultant was delayed in surgery at another site. Clinics sometimes ran late for this reason rather than being cancelled and patients were informed of the delay. The trust did not collate figures on appointments cancelled by the hospital or by patients so could not supply this data.
- The "Did Not Attend" (DNA) rate for the hospital where patients failed to turn up for appointments was 10%. This was worse than the England average of 7%. Managers were not aware of any action plans to improve this, for example, sending reminder texts to patients. Further appointment letters were sent or the patient was referred back to their GP if they failed to attend more than once.
- Patients were given a choice of appointments at clinics where possible.
- Consultants could adjust the length of appointments to accommodate new patients and follow-up appointments.
- Additional clinics were sometimes arranged on a Saturday to reduce any backlogs.
- The patient tracking list was clinically led. This tool measured progress on the 31 and 62 day cancer

pathway. It was used to solve individual patient issues on the pathway e.g. Delayed tests or surgery. The meetings were attended by clinicians and consultants and were held at all four sites. The attendance of consultants and clinicians was good practice.
- The trust had no mechanism to measure the number of patients waiting more than 30 minutes in clinic or the proportion of clinics that started late.
- In radiology, to reduce reporting times, CT scans were outsourced to reporting radiographers in Australia overnight from 8pm, using a "follow the sun" model. Follow-the-sun is a type of global workflow in which tasks are passed around daily between work sites that are many time zones apart. Such a workflow is set up in order to reduce project duration and increase responsiveness so CT scans could be reported on 24 hours a day.
- There was a dedicated cannulation room that ensured good access and flow into the CT Scan suite.

Meeting people's individual needs

- The trust had play specialists available in paediatric outpatients from Monday to Friday 9am to 5pm.
- In the Patient Led assessment of the Care Environment (PLACE) assessments, the hospital scored 82.8% in the Lucy Pugh Outpatients Department and 82.8% in Outpatients A for treatment of persons living with dementia. So could improve on the environment for persons living with dementia. We did not see any action plans to make the necessary changes highlighted in the assessments.
- Bariatric patient beds were available in outpatient clinics and could be moved to the appropriate room as and when required.
- Some patient leaflets were available in different languages, for example, Urdu. Interpreters could be pre-booked to attend clinics with patients. There were 107 bank interpreters and 11.9 WTE substantive interpreter staff in the trust in the ethnic health team. Interpreters were based on-site at the hospital. At short notice, Language Line interpretation service were also available. The trust did not allow interpretation by relatives. During 2015, 84 languages required interpretation.
- Videos were available on the trust website regarding what to do when you are feeling unwell. The videos were available in English, Arabic, Bengali, Punjabi and Urdu.
- The interpreter service also provide British Sign Language interpreters for deaf patients. Patients with a visual impairment could request documents in braille or large text and documents could be translated into different languages.
- The trust had a learning disability service that was part of the safeguarding team and whose purpose was to ensure that patients with a learning disability received an excellent standard of care. The service assisted patients when they came to the hospital and ensured necessary reasonable adjustments were made for them. The team worked with learning disability liaison nurses across the trust and gave training and advice to staff so that they could give better care to patients with learning disabilities.

Learning from complaints and concerns

- Complaints were handled in line with trust policy and were resolved locally wherever possible. Patients were initially directed to the Patient Advice and Liaison Service (PALS). PALS leaflets were available in departments.
- The trust had recently ensured that PALS were more "customer facing" with desks within each hospital.
- The trust had recently reviewed their Complaints Policy and introduced clear guidelines on expected response times. Complaints were graded on severity and were to be investigated accordingly. We have however, seen instances where complaints were not responded to within the expected timelines and there appeared to be a need to embed the recent policy, clear complaint backlogs and fill staffing vacancies on the Complaints Team. The trust had action plans in place to improve the service.
- Complaints were an agenda item on the monthly directorate meetings and details were fed down to operational managers for feedback to staff.
- In outpatients, the manager tried to deal with complaints informally at the first instance and would make direct contact with patients to apologise and try to resolve the issue. Feedback was given to staff at team meetings to encourage learning and improvement.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Good

We rated this service as good for Well-led because:

- Staff and the public had been engaged and involved in developing the trust vision and values and five year strategy.
- Staff were aware of and being supported through ongoing changes across the Greater Manchester Health Economy and the trust had engaged external management consultants to carry out an option appraisal exercise and support staff in any new configuration of the trust and its services.
- Quality and performance were monitored through a dashboard, governance structures were in place and there were departmental risk registers. The risk register reflected the risks and there were clear actions and control measures in place with specified timeframes and responsible individuals.
- The outpatients services were well-run and the manager worked well with the Band 6 Deputy. Staff were well-informed about any changes, there were regular team meetings and there appeared to be an open and honest culture.
- Staff were more proud to work in the trust than they had been in recent years. Staff said that they felt respected and valued and thought that managers were supportive. Staff knew how to report and were encouraged to speak up about concerns.
- Staff were encouraged to undertake further learning on areas of interest with a view to becoming local specialists or link nurses. Link nurses were utilised throughout the hospital, including outpatients and diagnostic services.
- The trust had an awards scheme to recognise quality and innovation in individual staff and teams

However:

- There had been no clinical director in pathology services since October 2015. The clinical lead in cellular pathology had also left and the service manager had no one to report to at the time of inspection. Recruitment for the posts was underway.
- Leadership at Band 7 level in radiology was weak and there were knowledge gaps around the importance of documents that should have been present in hard copies and signed by staff.

Vision and strategy for this service

- Since 2014 the trust has redeveloped their vision and values (Quality-driven; Responsible and Compassionate). They had developed a five year transformation map or strategy with the ultimate goal of being able to describe themselves as "A leading provider of joined-up healthcare that will support every person who needs the services, whether in or out of hospital, to achieve their fullest health potential."
- The vision and values were displayed throughout hospitals in the trust.
- Staff felt that the vision and values for the trust were appropriate and were motivated by them.
- Although the trust had a five year forward plan, there were strategic changes taking place to the way in which health and social care was delivered across Greater Manchester as a result of Devolution Manchester. Changes had not been finalised at the time of our inspection.
- The trust had engaged external management consultants to carry out an option appraisal exercise, which included outpatients, radiology and pathology services, and look at supporting any new configuration of the trust as part of Devolution Manchester. Staff told us that they were unsure of how their service and the trust would look in the future when Devolution Manchester commissioning and tendering became more active.

Governance, risk management and quality measurement

- Quality and performance were monitored in outpatients through a dashboard. This covered data such as sickness rates, new complaints, RTT rates, bed occupancy figures and additional information, such as appointment cancellations and DNA (did not attend) rates.
- The outpatients, radiology and pathology departments were part of the support services division. The director of the division chaired monthly meetings about the

governance of the services. The meetings also covered targets for all services within the directorate. Action plans were put in place where services were not achieving targets.
- Departmental managers met monthly about operational issues; team meetings were held every second week in outpatients.
- Consultants met monthly and held audit meetings with the interim Medical Director to discuss clinical audits and outcomes.
- A trust cancer performance meeting had made 35 improvement recommendations. There was an action plan in place and there had been timely resolution of all the recommendations.
- There was a radiation safety group who met every three months. Agenda items included equipment, radiation incidents, dose audits for radiologists and radiographers. They produced an annual report. However, despite this forum, we found there was only one set of local rules present at the time of our inspection and radiation risk assessments were absent. Staff had not signed the documents to indicate that they had read and understood them.
- There was a departmental risk register for radiology and outpatient services. The registers contained actions and target dates for the management or resolution of the risk. The Divisional Quality and Performance Group were responsible was responsible for reviewing the risk register.
- In outpatients, the manager proactively telephoned patients who had made a complaint, in order to apologise and to try to resolve the issue at the earliest opportunity.

Leadership of service

- There had been no clinical director in pathology services since October 2015. The clinical lead in cellular pathology had also left and the service manager had no one to report to at the time of inspection. Recruitment for the posts was underway. There was no adequate escalation or oversight process in place as a result of this.
- The manager of the microbiology labs reported that the trust board were very approachable and visible.
- Staff reported that they believed that they could trust the trust leadership and that they were visible and approachable. They knew the faces and names of the leadership team.
- Strong leadership was not provided at Band 7 level in radiology and there were knowledge gaps around the importance of documents that should have been present in hard copies and signed by staff. For example, the absence of local rules and radiation risk assessments.
- The outpatients services were well-run and the manager worked well with the Band 6 Deputy. Staff were well-informed about any changes, there were regular team meetings and there appeared to be an open and honest culture.

Culture within the service

- Managers reported that staff were visibly more proud to work in the trust now than they had been a few years ago. This followed the appointment of a number of new staff at executive level and increased staff engagement.
- Staff were proud of the microbiology service that was delivered from a state of the art facility. Staff showed concern about what would happen when “Devolution Manchester” took effect and whether they would take on more GP work and send more hospital work to the Virology Centre at another trust.
- Staff said that they felt respected and valued and thought that managers were supportive.
- Staff were aware of the bullying and harassment policy and thought that the trust encouraged speaking up about concerns.
- The trust had an awards scheme to recognise quality and innovation in individual staff and teams.
- There were low sickness levels in pathology services and outpatients. There were two staff on long-term sickness in outpatients and one was about to return to work.

Public engagement

- The public had been involved in the development of the vision, values and strategy for the trust. They had used crowd sourcing as a way of obtaining ideas and information from a large group of people.
- The radiology service carried out patient quality surveys post experience and had recently held an open day where patients were invited to look round the department and given an awareness of the equipment and procedures. We were shown an email following the event that showed that there had been very positive feedback.

Staff engagement

- In redefining the trust vision and values, the trust engaged staff by using web-based crowd sourcing technology, enabling every member of staff to contribute to the strategic direction of the trust. Over 14,000 comments and ideas were received and they were summarised and presented at a full day interactive strategy summit attended by over 320 staff. Further engagement took place and, in total, over 1700 individuals have contributed over 27,000 comments in making the trust transformation map and values. The transformation map is a five year plan up to March 2020.
- A Monday message sent out to all trust staff from the Chief Executive was well received.
- Staff were encouraged to undertake further learning on areas of interest with a view to becoming local specialists or link nurses.

Innovation, improvement and sustainability

- Service managers at the hospital were on a seven week on call rota for out-of-hours. This meant that for one day a week (Monday, then Tuesday etc.) they would be responsible for the whole hospital site between 5pm and around 10pm and would need to sort out any staffing problems or other issues e.g. a staff member not turning up for work in A&E. Following the seven-week rota there was a period of eight weeks off. A manager reported that the rota system made the managers work better as a team across the site, understand each other better and on going clinical pressures. The morning after an on-call shift, the managers only undertook administration tasks to minimise the risk of clinical errors.
- The trust trained and utilised link nurses throughout the hospitals, including outpatients and diagnostic services. Link nurses had specialities that they were the lead for and received more advanced training and clinical updates so they could advise and train other team members. Examples of specialist link nurses were for specialists in dressings, diabetes, ANTT and dementia.
- In outpatients, the manager reported that sustainability of the service had not been an issue. Although they had a budget to adhere to there had never been dangerous staffing levels and budgets for bank staff to fill vacancy or sickness gaps had never been refused.
- The trust had made significant investments into some services to improve their responsiveness and effectiveness and ensure competitiveness going forward.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must take action to ensure that level 2 patients on the high dependency unit at the Royal Oldham Hospital are managed in accordance with the national guidance and standards for critical care.
- The trust must take action to reduce the numbers of delayed and out of hours discharges from both level 2 and level 3 critical care facilities.
- Royal Oldham Hospital must take action to ensure that any DNACPR decision is supported by the consent of the patient.
- Royal Oldham Hospital must take action to ensure that where a patient appears to lack capacity to consent to a DNACPR decision, a mental capacity assessment must take place prior to the decision being taken.
- Royal Oldham Hospital must take action to ensure where a patient has been assessed as lacking capacity to make the DNACPR decision a documented discussion with patient's family takes place prior to the decision being taken.

For urgent and emergency services:

- Ensure that patients attending the urgent and emergency department are assessed and treated in a timely manner.
- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the urgent and emergency department.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The trust should ensure that care within the level 2 critical care unit is clinically led by a consultant in intensive care medicine.
- Ensure that there is a supernumerary band 6/7 shift co-ordinator on duty 24/7.
- Ensure that there are standard protocols in place for the administration of intra-venous infusions on the level 2 high dependency unit.
- Ensure that the critical care risks on the risk register are regularly reviewed and updated with actions.
- Ensure that the existing arrangement for the servicing and repair of equipment assures them that all critical care equipment is fit for purpose.
- Ensure that it takes action to ensure that DNACPR documentation is completed in accordance with its own trust policy.
- Consider how it can embed training on Duty of Candour to all staff.
- Consider how it can develop and expand the critical care outreach service to provide cover 24/7.
- Consider how it is going to embed the delirium strategy into the day to day care of patients receiving critical care.
- Consider how it is going to meet the intensive care society standards for the provision of pharmacy and allied health professional support to the critical care service.
- Consider a full review of the staffing requirements to introduce seven day specialist palliative care services at the hospital.
- Consider how to respond to the complex symptom control needs of EOL patients out of hours.
- Consider how to provide training to middle grade doctors about the complex symptom control needs of EOL patients.
- Consider whether the current SPCT staffing levels are sufficient to meet the current demands on the service.
- Consider how to involve SPCT in the service developments required to implement the EOL strategy.

Outstanding practice and areas for improvement

- Consider the level of support and education required from EOLC facilitation team for FGH to embed the use of the IPOC documentation across all its wards.
- Consider how to develop a sensitive tool to ascertain when incidents occur related to EOL issues.
- Consider how to provide SPCT staff with feedback from incidents submitted to enable action to be taken to prevent such incidents reoccurring.

For urgent and emergency services:

- Consider taking appropriate actions to improve the processes for reviewing and managing key risks to the services.
- Consider improving the processes for monitoring and improving the management of sepsis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. - (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which as registered person must do to comply with that paragraph include - (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (g) the proper and safe management of medicines; (I) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

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

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13. - (1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users.

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10. - (1) Service users must be treated with dignity and respect. (2) Without limiting paragraph (1), the things which a registered person is required to do comply with paragraph (1) include in particular -

This section is primarily information for the provider

Requirement notices

(a) ensuring the privacy of the service user,

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

17. - (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to -

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

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